THE AMERICAN JOURNAL of OCCUPATIONAL THERAPY

FFICIAL PUBLICATION OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

Vol. III No. 1 1949 January--February

ANNUAL
ONVENTION
troit, Michigan
g. 23-25, 1949

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Published bi-monthly by the American Occupational Therapy Association.

Published bi-monthly by the American Journal of Occupational Therapy. Publication office 9120 Baltimore, Chicago 17, Illinois. (Address all communications to Editorial and Advertising Circulation Departments 1313 East Elmdale Court, Milwaukee 11, Wisconsin.) Entered as second class matter at Postoffice Chicago, Illinois, under the act of March 3, 1879. Subscription rate $5.00 a year $1.00 per single issue.

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Official Publication of the American Occupational Therapy Association

VOL. III, NO. 1 JANUARY-FEBRUARY 1949

Occupational Therapy in the Treatment of Neurosurgical Patients

HENRY M. SUCKLE, M.D.* AND CAROLINE THOMPSON, O.T.R.**

Occupational therapy is an important adjunct in the treatment of neurosurgical patients. In the early stages of serious central nervous system involvement the primary aim is preservation of life. When this crisis has passed and the patient re-enters the conscious world he is subjected to a psychology of illness which carries forces of good and evil concerning his welfare. The agony of pain and the frightening effect of impaired function causes a dependence on hospital personnel and family. This "leaning on others" is a great aid in obtaining the complete cooperation of the patient when rest is needed for well ordered healing. The acceptance of assistance normally should give way later to an impelling desire for independence of thought and action on the part of the convalescing patient. Too frequently, the convalescent accepts the easy circumscribed life of hospitalization and refuses to exert himself to gain complete recovery. In the desirable change toward the recovered individual, occupational therapy may play a large role in awakening and directing the "will to be well."

PHASES OF RECOVERY

In the recovery from any severe involvement of the central nervous system whether by expanding growth or injury, three phases may be recognized: (1) the return to consciousness, which may take seconds to weeks (2) active convalescence consuming a week to months at the end of which time the patient is able to get up and about, and (3) the long return toward the former capabilities which may take several years. The appalling length of time for central nervous system recovery may be understood in considering the complexity of function. Defeatism has no place in the treatment of neurosurgical patients for this attitude may be quickly dispelled by anyone knowing the remarkable recovery gained in many individuals. Patience, encouragement coupled with forthright and well timed definitive treatment of neurosurgical patients yields results equalling the highest expectations.

Head injuries in civilian life are not prone to produce focal neurological defects like aphasia, hemianopsia or localized paralysis as the gunshot head wounds of war. In the generalized brain injury as cerebral concussion and contusion there may be long periods of clouded consciousness which may be partly cleared by relating familiar experience to the patient or playing favorite music. The great enigma of the convalescing head injury patient is the post traumatic syndrome consisting of the onset of headache in the recovery stage which is aggravated by emotional tension or exertion. This syndrome may include paresthesias of the

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scalp, dizziness and insomnia. Penfield has indicated that a great percentage of these cases harbor scar tissue bridging the sub-dural space and exerting traction on the sensitive dura mater. Other investigators have analyzed large series of head injuries and have found the post traumatic state most frequent among unstable individuals sustaining a diffuse non-penetrating and sometimes mild head injury. Occupational therapy cannot correct the psychological weakness of the individual but in the stage of recovery entertainment prevents self preoccupation and projects awaken new interests and assure the patient of his own worth by demonstrating his ability to complete a useful object.

Specific focal neurological defects may occur in head injuries as well as in brain tumors. Localized tumors and head injuries differ in their effect on the nervous system as compared to the infiltrating brain tumors. Great improvement in function may be expected following recovery from focal brain lesions due to a penetrating injury or the removal of an extrinsic compressing tumor as a meningioma. The improvement in function may take several years but it appears in a remarkably great number of cases. The removal of an infiltrating tumor sometimes produces an improvement which may last five or more years but more often there is a defect in function which increases as the tumor recurs and infiltrates the surrounding cerebral tissue. Occupational therapy may provide entertainment and amusement for all cases but great effort should be expended on those more likely to recover, namely the focal head injuries and benign tumors.

TREATMENT PROGRAM

Focal defects as paralysis or aphasia lend themselves to re-education and a great increase in function may be expected following the removal of a meningioma or the elevation of a depressed skull fracture fragment involving the motor areas of the cerebral cortex. The initial loss of function is frightening to a previously facile individual and aphasia is a very demoralizing handicap. Reassurance, and stimulation of the patient's interest in his surroundings helps to draw out these individuals and re-establish a hope that they may enjoy the pursuit of their former life. The active therapy to a paralysed limb may be assumed by physical therapy and the aphasic enrolled in speech training. This treatment regime is distinctly more effective when coupled with correlated occupational therapy. The exercises for movement of the paralyzed arm or leg may quickly become tiresome but when cloaked in project-making, the drudge of routine is dispelled in the enthusiasm of accomplishment. The roughly hammered ash tray or a hammer marked book-end may appear crudely fashioned to the artisan but this represents a long step forward for the handicapped. More intricate tasks quickly bolster confidence. The aphasic is less conscious of his word loss when he can speak in the project language as the finished product requires no explanation. The familiarity with tools and crafts gives the aphasic a basis for a new language and with this prized acquisition the older formal speech more readily returns. Many tumor and head injury patients exhibit a mental dulling in the early phases of recovery which is disturbing, for the individual does not always forget his former capabilities. Occupational Therapy may re-educate the individual in his particular field and gain a great measure of confidence in his ability to return to his former occupation. In cases where return to former livelihood is impossible, occupational therapy and rehabilitation may help to relocate the individual.

The threat of epilepsy or convulsive seizures stalks the convalescence of many neurosurgical patients. The great fear of seizures on the part of the patient and his companions leads to withdrawal from healthy contact with people. This seclusion magnifies the condition which may not be serious. Proper drug therapy controls a great percentage of seizures. Education of the patient and his family may be hastened by the proper approach of the occupational therapist. The reassurance and suggestions offered in the hours spent in occupational therapy may dispel many fears. Routine daily medication can be more easily accepted and the horror of the seizure minimized when objectively regarded as only part of an illness. The occupational therapist should be acquainted with the emergency care of the epileptic. The danger of proximity to moving machinery should be recognized and the seizure susceptible patient steered into work without such danger. When the continued occurrence of seizure precludes return of the individual to his former pursuit, occupational therapy may cooperate advantageously with rehabilitation in readjusting the patient's life.

Trauma to the spinal cord often has devastating paralytic effects which cannot be cate-

gorically defined as recoverable or permanent. Prompt and definitive neurosurgical care is again only the first step in recovery. Occupational therapy first reestablishes the patient's interest in his surroundings. This is of great importance for these individuals have a clear mind which is acutely aware and depressed by the vast implication of their paralysis. The occupational therapist may carefully select projects that may be easily controlled by the weakened hands or moved by the paretic legs. The complexity of the work may be changed to parallel the improvement in function of the paralyzed limbs thereby providing a valuable adjunct to physical therapy. In complete transverse cord lesions the recovery may be minimal and occupational therapy must be aimed at utilizing the remaining intact functional elements of the body. Large handled tools must be made for the poor grasp of the weakened hand. The partly paralyzed extremity may be reeducated to a great degree and again provide for the patient's needs. Change of occupation is frequently necessary and occupational therapy may take part in directing these individuals towards new fields of employment. Spinal cord tumors are a heartening segment of neurosurgery for over three-fourths are benign and may be removed with remarkable return of normal function. In the prognosis following spinal cord involvement, a two-year minimum must be set for maximum return of function and this period should be actively spent in re-education with physical and occupational therapy.

Injuries of the peripheral nerves are becoming more frequent with the increase in automotive and industrial accidents. Prompt exploration, with definition of the nature and extent of injury is the first important step in treatment. Resuture of the divided nerve ends is the surgical treatment of choice. When this is not possible due to a large defect in continuity, a nerve graft or tendon transplant often yields a useful limb. Physical therapy may use specific exercises to move and strengthen the weakened muscles and joint. These exercises may be amplified in occupational therapy by performing certain tasks to move the specific muscles. Many projects may promote the use of the hands and arms as weaving, and foot-powered tools strengthen the lower extremities. The finishing of a project aids the convalescent in reaffirming his faith that he may again equal his former self.

The treatment of neurosurgical patients has been vastly extended and improved by the increased experience gained from two wars, basic neurophysiological research and the testing and application of newer surgical techniques employed by a growing group of trained neurosurgeons. Therapy must not stop when the surgery wound is healed, for there is a great amount of recovery which may be elicited by the proper use of occupational therapy. Unlike other bodily ailments surgical diseases of the central nervous system more markedly impair the measured usefulness of the individual. In many instances the worth of the individual patient may be regained when occupational therapy is the driving force in convalescence.

Occupational Therapy — A Definitely Prescribed Treatment for the Neuropsychiatric Patient

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A study of the history of psychiatry leaves little doubt as to the value of occupational therapy and its use in mental institutions. However, only in rare instances has this therapy really had the opportunity of proving that it can play a definite part in the treatment of the neuropsychiatric patient. Too often, to the despair of trained and conscientious therapists, it has been used merely as an aid in hospital maintenance, to keep the patient off the ward, or at best as activity to keep him busy and more satisfied with his lot. Those who understood its true and broader purpose have had a constant struggle to make others realize that it is more than manual labor or mere craft work performed to pass away the time. During the recent war, however, many Army and Navy physicians saw occupational therapy help in the recovery of our war casualties and came to appreciate it as therapy. Since that time it is continuing to prove its value in several progressive hospitals.

Winter Veterans Administration Hospital at

Topeka, Kansas has an unusual opportunity to illustrate to the members of the medical profession just how occupational therapy can best be used to treat the neuropsychiatric patient. This hospital is one of the largest psychiatric training centers for doctors, nurses, psychologists, social workers, and other professional groups, who all receive some information in this field as a part of their training. As in other Veterans Hospitals, occupational therapy is set up as a part of Physical Medicine Rehabilitation and coordinates with each of the other departments in this program. These are: Physical Therapy, Corrective Physical Retraining, Manual Arts Therapy, and Educational Retraining. All of the activities in each of these sections as well as occupational therapy, are given as prescribed treatment, and for this reason one simplified prescription form for all of Physical Medicine Rehabilitation has been designed and used successfully. This form includes places to indicate which departments are to treat a patient, pertinent information about the individual, and most important, the definite treatment aim for which the therapist is to strive while working with him.

Each new group of student psychiatrists are given some training in each of these therapies and shown how to prescribe them when desired. A booklet has been compiled and distributed, which serves as a guide to the psychiatrists in training and gives other hospital personnel an understanding of how these activities are used as treatment. This guide suggests five general treatment aims and how they may be carried out in various activities. The doctors usually follow these suggestions but at times may prescribe other objectives more pertinent to the individual concerned. The five general aims suggested are as follows:

1. To provide opportunity for the relief of guilt feelings.

   This, as a general rule, is prescribed for the patient whose hostility is turned upon himself and is depressed, self-depreciating, dejected, and feels unworthy of any kindness.

2. To provide opportunity for socially accepted creative accomplishments (narcissistic gratification).

   This is usually given for the patient whose libidinal interest is in himself to the exclusion of others and who has a need to express his fantasies and love of self in acceptable ways.

3. To provide opportunity for acceptable expression of aggression.

   This is prescribed for the individual who is surly, stubborn, combative, demanding, or destructive who needs to express his hostility in an acceptable manner. It is often used, also, for the passively aggressive patient who is inwardly hostile toward others.

4. To provide opportunity for vocational adjustment and the learning of new skills.

   This aim is given often for the patient who needs stimulation in some new trade or skill and adjustment to working conditions. It is used also for the person who has become content to live a passive dependent life or one who needs to adjust himself to a physical or mental handicap.

5. To provide an opportunity for the development of a hobby and activity interest.

   Physicians often prescribe this aim for the patient who has the need for the gratification he can receive from pursuing an interesting hobby. A patient can often live a happier and more adjusted life if he has this interest to occupy his leisure time. It is also prescribed for the chronic patient who, because of his long hospitalization, needs new interests to occupy his mind and his time.

Besides these aims, doctors are asked to give any other information which may be helpful in treatment. They are requested to write an extra note about any peculiarities an individual may have, as well as his interests and aptitudes. For example, race prejudice, sensitivity to noise, agitation toward a particular patient, or other abnormal traits. Although certain attitudes are assumed with certain types of patients, as will be discussed later, it is always helpful if the psychiatrist suggests how much attention and solicitude he thinks his patient should receive.

Everyone treating the patient should work as a team toward his recovery. The occupational therapist should be considered as an important member of this team and be given any information about the patient which might help her better understand his problems. She requires more than the prescription which gives her only the few necessary facts to begin treatment. As a psychiatrist becomes more familiar with his patient's problems and his underlying difficulties, it is helpful to the therapist if he discusses these things with her. This is encouraged, and

doctors are requested to make out new prescriptions each six weeks or to check and renew the old ones. They are asked to visit the shops and observe their patients at work. Often an individual's behavior is quite different in the shop than in his ward, and observing him in this environment may provide further aid in his diagnosis or treatment. Often an individual will portray his inner conflicts and desires in his drawings, paintings, and modeled articles and these may be studied by his physician.

Progress notes on the behavior and activity of each patient under treatment are written regularly. If a doctor feels, after reading his notes, that sufficient progress is not being accomplished with a particular patient, that the treatment he is receiving or the activity in which he is engaged is not best for him, he may discuss it with the therapist concerned so she may change the treatment she administers.

The psychiatrists are required to prescribe treatment, but it is the responsibility of the therapists to devise the activity and adapt the work to the patient's individual needs. Inasmuch as possible his intelligence, physical limitations, emotions, anxieties and previous history are kept in mind throughout his treatment. Each patient is considered individually and the activities in which he engages are those which will help fulfill his particular treatment aim.

Occupational therapy, as a part of the rehabilitation program in Winter Hospital, cares for the more acutely ill, and those patients not yet able to cope with the more complicated activities of manual arts therapy. It provides guided activities for these patients in closely supervised shops where each individual works at a carefully selected and adapted craft and at his own level of achievement.

VARIETY OF TECHNIQUES

Efforts have been made by the occupational therapy staff to adapt a great variety of crafts which can be successfully used as specific treatment. Certain crafts are found valuable because their techniques are quite flexible and permit much modification, and can therefore be used to meet many needs. Some are selected because through the years they have proven their value in therapy. When choosing a craft, therapists have such questions in mind as to whether it will produce something worthwhile, if it will interest the patient, if the patient can produce most of the work necessary to complete the project, and most important, if it can be presented and used in such a way that it will be therapeutically beneficial to the patient. Some crafts are chosen because they require few or no tools, others for required repetitive or monotonous movements, some for their opportunity for creative expression, some for their resistive and punitive value. Inasmuch as possible, the over-used and antiquated crafts such as basketry and chair caning are not found in our shops. However, any craft for which the equipment may be made available is utilized when it is felt to be valuable therapy for any individual. The therapists strive to have each patient complete his project to the best of his ability and whenever possible to make something both beautiful and useful. However, it is kept in mind that the finished product in some cases means little in itself, and that the importance of the activity is what it has done for the patient.

As has been stated, many various crafts are utilized in this program, and a few of the more important ones will be discussed to show how they are used as definite treatment. Weaving, one of the oldest arts, is most adaptable, and there are many diversified ways of employing it as therapy. Simple hand weaving can be accomplished by the very acutely ill and is frequently used as a beginning activity with such a patient. As one becomes more oriented and improves in mental and motor coordination, he is able to learn the use of a two pedal loom. This is adapted and graded by the size of the loom, the size and texture of the material, and by the chosen colors. An individual having the power of concentration and coordination can manipulate the various pattern looms, which when they are set up with intricate patterns are used for a patient requiring a very exacting activity. Weaving has been found to be excellent for carrying out the various treatment aims. It can be given as quieting work if it is that of a simple repeated twill with soft yarns of cool colors. It can be most stimulating and interesting with intricate patterns, harsher textures, and bright colors. Heavy looms with strong beams used to beat coarse materials are employed for a patient requiring an outlet for his aggressions. Tearing and cutting cloth into strips for rags is another acceptable way used to sublimate hostile actions. The finished articles are frequently beautiful and useful and give a patient narcissistic gratification. Creative ability can be used in planning the project, choosing the colors, and working

out new patterns. A depressed patient is often given simple monotonous weaving with coarse rags or uninteresting materials. If very depressed, withdrawn, or lacking in coordination, a patient may roll yarn into balls or on to shuttles for others to use. Tangled yarns are often unraveled and straightened by the individual in need of a punitive task. At times a capable patient who needs monotonous or tedious work is taught to thread a loom. It is surprising how many men like to weave, and usually those who once thought of it as "sissy work" ask to weave before being in a shop very long.

Woodworking is always a popular activity, especially with men, and so is used a great deal. This craft is graded in the various shops because of the tools and equipment available in each. Even a suicidal patient may work with wood by sanding and finishing book ends, plaques, and other projects. To the acutely ill patient, who is allowed only simple hand tools, such projects as coping saw work are presented. These projects involve the use of a few tools and small articles and can be completed in short periods of time. If a patient is allowed the use of all hand tools and has enough contact with reality and coordination, he may make an object which requires squaring and joining of several parts, planing of unfinished wood, and hammering. The better oriented and capable patients are allowed the use of power tools such as the electric jig saw, band saw, lathe and drill. Power tools are provided in two of the closed ward shops and have been used by the majority of patients who have attended them. It is felt that it is worth the risk that may be taken to give these patients normal activity, and as yet only the very minimum of accidents have occurred. Carpentry proves to be one of the best activities for the individual who requires an approved outlet for his aggressions. Sawing heavy wood, which gives much resistance, is especially applicable. Hammering and filing are also employed, and some type of such work can usually be given to even the most acutely ill. The patient, when indicated, is encouraged to plan his own design for his project, thus giving him creative expression. The depressed patient can be given menial or punitive tasks as filing or sanding wood for others, cleaning and sweeping the sawdust and scraps from the tables, machinery, and floor. Woodworking is stimulating because it is an active one and presents so varied an assortment of activities and projects. The completed projects are usually worthwhile and often pleasing to the eye which gain admiration from others and praise from the instructors.

Woodcarving is also offered and enjoyed by many in the wards as well as in the shops. It is given to the patient who is allowed the use of a knife and includes such activities as whittling small figures, chip carving, etc. This activity is often presented the patient who has hostilities and some projects require very tedious and exacting work, which are given to one who needs to regain his compulsive habits. Wood suitable for carving is a popular medium with the patient with creative ability. Carpentry is an excellent craft for prevocational training, and both it and wood carving may develop into hobbies after a patient is released from the hospital.

Pottery making has long proved its value as therapy. It is found to be an activity which arouses interest and can be graded to meet the mental capacity and adapted to fill the needs of most any patient. Simple bowls, ash trays, and dishes may be made without the use of harmful tools by pulling up the corners and pushing prepared slabs of clay into interesting shapes. Even an acutely ill and regressed patient is able to make vases and mugs by the hand coil method. A more capable patient is often taught to use the potters wheel. Pottery offers endless possibilities for those who wish to create. There is no special pattern to follow, but the patient creates his piece as he works and forms it to please himself as it is being built. Clay is soft and pliable and simple short time projects prove to be quieting to the excited patient. On the other hand, creating something interesting in a short period of time is stimulating to another. An excited or aggressive patient is often benefitted by wedging the clay. Kneading hard clay and getting it ready for others to use is a goo activity for one requiring menial tasks. There is a great deal of cleanup work required after working with clay, which is used to teach good work habits and is a suitable task for a patient with guilt feelings. At times work with pliable clay or plasticine is given to a regressed patient as a sublimation for smearing. Clay modeling is also carried on in the shops and is most valuable for its creative value.

Plastic from which so many beautiful articles can be made is a most popular medium. Because it is a new material and so many beauti-

fully finished pieces are made from it, a patient who rejects everything else often will agree to "try his hand" at plastic work. The material when well polished, has a brilliant mirror like surface and can be dyed many pleasing colors which make it a stimulating craft. Very simple projects may be made which take few tools and a short time to complete. Most any patient is able to make a simple plastic project, and the craft is easily adapted. Sanding and polishing rough plastic is a task often given to a patient for whom the expiation of guilt is the aim of treatment. Hostilities are often worked out in sawing and filing and using an electric tool for etching and carving. There are many projects which require much skill and detailed work to use as compulsive activities. Plastic craft is often presented to a patient who needs to acquire a hobby interest as it can be done with a minimum of tools and equipment.

Although leather art craft is an overworked occupational therapy activity, it is still an excellent one. Most patients enjoy leather work, and the treatment aims can be accomplished through this medium. It is easily graded and can be adapted to the ability and needs of most any individual. It is often used as a quieting activity as some projects require no noise and the lacing of the article is very repetitive and monotonous. It is stimulating and interesting to most and in a relatively short time very attractive and worthwhile articles are completed. As a patient is usually encouraged to send his projects home, these make appropriate gifts to relatives and friends as they are useful and easily sent through the mail. Making worthwhile gifts for others is gratifying to most individuals. Aggressive or excited patients are often given leather stamping as an activity. Planning new patterns for leather construction and designs for their decoration is used as a creative activity. Leather is another craft which is taught as a hobby and at times may become a vocation.

Besides the crafts which have been discussed, metal craft, knotting and braiding, fine and graphic arts, and most of the minor crafts are used in treating patients in the occupational therapy shops. Metal craft is very popular and involves about the same processes as wood and plastic work so is used as variety in securing the same objectives. Knotting and braiding are quiet repetitive work and require no tools. Fine arts in the form of designing, finger painting, drawing, and painting are used especially to provide opportunity for creative accomplishment. Finger paintings and drawings are often studied by the psychiatrists for diagnostic purposes. Block printing is a stimulating craft and gives an outlet for hostilities by cutting the design and hammering the block when printing. Stenciling and screen printing are creative and give narcissistic gratification as do many of the minor crafts. Needle work in all forms is used a great deal, especially for the women patients and can usually be adapted to meet their needs. Many male patients enjoy rug crocheting, using large hooks and heavy material, rake knitting, mat making, etc. These are often presented as training for coordination or as monotonous and repetitive work.

The hospital includes a well equipped greenhouse, and the activities carried on by patients here and in the gardens are under the direction of occupational therapy personnel. These activities have been carefully adapted to carry out the physicians' prescribed aims, and certain types of patients seem to benefit more from them than any others. Any patient may be prescribed to work here unless he is suicidal, assaultive, or one who might escape. A patient having a need for ego satisfaction often secures it from cutting flowers and arranging attractive bouquets and corsages. Another may deliver plants to the various wards, offices, and dining rooms throughout the hospital. A patient may work off pent up emotions by digging in the gardens, pulling and cutting weeds, or breaking up rocks to be used for drainage. A depressed patient often screens the dirt, weeds the flower boxes, transplants small seedlings, cleans the greenhouse, washes flower pots or does other similar menial tasks. Special lessons in horticulture are given if one wishes to follow it as a hobby or develop it into a future vocation. The vegetables and flowers produced are used by the hospital, but the primary purpose for their cultivation is to fulfill the needs of the individual patients.

SOCIAL NEEDS

A majority of neuropsychiatric patients need some degree of socialization. Although occupational therapy in our hospital is chiefly individual treatment, with each patient taking part in the activity which suits his particular needs, socialization is bound to take place in an occupational therapy shop. The shops have a relaxed atmosphere, and people are engaged in work

they enjoy. Therapists keep in mind the value of socialization and try to take time to have friendly talks with the shy, withdrawn individuals. Patients working on similar projects are seated together and usually will enter into discussions about their work. Record players and a variety of records are provided in each shop, and groups gather at intervals during the class period to listen to music. There are always patients from more than one ward present in a shop and new contacts are possible. Group projects are frequently carried on, such as puppetry, or making articles for their wards. Others work together cleaning the shop at the end of the class. A patient finds it more pleasant to develop the habit of doing things agreeable to his neighbors, and this and the encouragement he is given to make things for others, helps him forget his own worries and conflicts.

As important as the chosen activity in treating a neuropsychiatric patient is the attitude used while working with him. The personnel of the department try to create a cheerful atmosphere by being friendly and treating patients as normally as possible. They try to be kind and understanding and show little impatience with the antagonistic or irresponsible patient. These are their general attitudes, but by following the prescriptions and from training and experience, the therapists determine the manner they assume with each of those they treat.

If a patient comes showing fear of the shop, the equipment, or others present, he is given as much reassurance as possible. He is not urged at the beginning to take part in any activity, but may be shown around the shop, introduced to other patients and personnel and seated by some one he may know. If he is treated in this manner, he is more likely to feel secure and participate sooner than if ignored or urged to commence work at the beginning. This type of patient is later offered projects at which he will be able to succeed and thus earn praise for his accomplishments.

Active friendliness, as a rule, is given the withdrawn, shy individual who needs to gain gratification and confidence in his own abilities. The therapist initiates the friendliness and gives special interest and attention to him whenever possible. Praise is given for any worthwhile thing this patient may do, and attention may be called to his work by displaying it, or showing it as an example to others. When feasible, an individual needing an outlet for his exhibitionistic desires is asked to teach others crafts he has learned.

The aggressive antagonistic patient is always a problem in a group, but the therapists try to ignore his behavior whenever possible and without any comment unless it is necessary. He is treated with passive friendliness, that is friendliness is given him but he is not indulged in his desires. His undesirable behavior is discouraged, and he is given praise when earned to encourage him in his acceptable activities. Therapists are patient while working with the argumentative person whose desires or demands are not feasible. Full explanations are given to the patient and substituting activities are offered to him to help him express his aggressive drives in an acceptable manner.

The passively resistive patient, such as the catatonic or other severely withdrawn individual, is treated with a matter of fact attitude by not overly persuading him to participate. He is spoken to in a friendly manner and given an opportunity to take part each time he attends a shop, but no persistence or argument is made. This type of individual, it is found, will decide to work more quickly under this procedure, than if he is urged to participate or if impatience is shown when he refuses.

A kindly but strict attitude is usually taken with the depressed psychotic patient. He is given monotonous work or a menial task, with the attitude that he is expected to do it and without much encouragement or praise. If very depressed and uncooperative, the therapist often takes a firm attitude and tells him in a positive and authoritative manner what he is expected to do. No comment is made about his self-depreciation, and there is no indulgence of his desires not connected with his work. It is believed, in this way, he will feel relief in having atoned for some of his guilt.

The occupational therapy department here, as in most other hospitals, does not have the personnel to give each patient the individual attention which is felt necessary for the best results. Also, a training center has the added difficulty of the constant change of doctors and nurses on the wards so that the therapist finds difficulty in becoming acquainted with each of the other personnel who treat and contact her patient. The program is comparatively new, and some of the therapists have just recently joined

the staff. However, being a part of such an institution where research and learning is constantly taking place, is an inspiration and incentive to the personnel to develop the field in which they work. Weekly lectures, which aid in understanding the basic psychiatric concepts, are given by the consultant from the Menninger Foundation and members of the medical staff. This knowledge as well as information gained from meetings and conferences is applied in the treatments which are administered.

It is felt that this department is working in the right direction and in time, with more experience and anticipated research, it will be able to prove to others what its therapists believe themselves: that occupational therapy is important and valuable as a specific part of the treatment for the neuropsychiatric patient.

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Play — A Child's World

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Play is a child's way of learning and an outlet for his innate need of activity. It is his business or his career. In it he engages himself with the same attitude and energy that we engage ourselves in our regular work. For each child it is a serious undertaking not to be confused with diversion or idle use of time. Play is not folly. It is purposeful activity, the result of mental and emotional experiences. These experiences, coupled with his reactions to them, control the character of the child's growth and development.

PLAY CHILD'S BUSINESS

Play is spontaneous. It need not be taught. The infant baby is probing to discover the world in relation to himself through play. As the baby kicks and moves his arms, he is learning to use his body. As he fingers the rattle, listens to it, puts it to his mouth, he is learning about physical phenomena—shape, weight, texture and size. A rattle feels hard, makes a noise, and tastes like a rattle!—not like his milk. He smiles and gurgles when his mother is near to bring certain delightful reactions from mother. He is learning social relations. These very simple forms of play are the start of his discovery of the world.

Play continues to be the child's business in experimenting, investigating, and learning. (Play is not a means of amusing a child to get him out of our way!) It has often been said that we never really learn anything unless we do it or experience it. It is no less so with children. We must realize this quality of learning and allow children first hand experiences. To give an example, a fourteen month old child was to be put in his fenced play yard. He objected to the gate being locked. It wasn't that he didn't want to be closed in, but that gate fascinated him. It was left unlatched and for thirty minutes, he pushed and walked out, pulled and walked in. What a discovery! The gate wasn't like the rest of the fence. He had to learn about it. No one could tell him in words that this was a gate and convey the idea of the gate.

We must give children a chance at learning things for themselves. They must have their own experiences, they must use their own instruments for learning: their eyes, ears, noses, and fingers. Learning through the use of words may satisfy us because we have accustomed ourselves to accepting the theoretical, but for the child whose senses are sharp and keenly perceptive, it is unfair to only describe physical phenomena to him. Seeing a bunny, feeling it, holding one in one's own hand is a surer way of learning than seeing a picture of one. Take for example, the little one who shouted, "Tiger, tiger!" when he saw a chipmunk in Central Park. That's what pictures of tigers looked like to him!

RESOURCEFUL APPROACH

Children need an uninterrupted time for play in a safe place. They need a chance to try and to try again. They need an opportunity to go ahead at their own rate of speed. An adult's presence must never be overbearing. "Don't pile the blocks so high, Johnny, they'll fall down." "Look out, don't get your hands dirty." A hundred do's and don't's will hamper the

outgoing resourceful approach that is to be developed in permissive play. The over-guided child will retreat into himself, make himself as inconspicuous as possible, repress his resentments and fears, and appear weak and incapable. Young children need supervision, of course; but not the variety that inhibits or instructs their every move.

A child needs to have approval and praise for the things he accomplishes. We cannot expect perfection, since it is illogical to impose adult standards on the quality of his performance. Tommy pointed gleefully at his painting, exclaiming, "Look at the boat I made." To our adult standards, his purple smears were far from any concept of a boat. But on saying, "A lovely boat, Tommy," he felt as though we thoroughly agreed with him and understood exactly what he was portraying. Tommy had not quite developed the skill of reproducing an image. Yet, had we said, "No Tommy, a boat doesn't look like that, it looks so and so—," Tommy's efforts would have been smitten and he might refrain from painting as a means of expressing himself again. He might even have interpreted our criticism as a rejection of himself.

An adult may image that he is encouraging a child into an activity by teasing him or by spurring him on, saying, "Freddy can do it, so can you." However, each child must progress at his own pace. Whatever the child does is at the moment his best effort. It must be accepted as such.

Approval for efforts and achievements gives the child encouragement, confidence, and pleasure in what he does. A favorable response gives him direction of activity since it tends to make him draw upon his own initiative for succeeding activities. This develops in the child, an outgoing resourceful approach toward play.

MATERIALS FOR PLAY

Children need materials to use in play, but these need not be elaborate, expensive toys. The simplest things will often serve them best, for their simplicity will serve as a springboard to the child's enormous imagination.

The very young child will like a soft toy, a doll carriage and housekeeping equipment, some little cars, paints, clay and blocks. The five-year-old likes these same things but adds a variety of toys with which he can display his increased physical prowess—roller skates, jump rope, and the like. Still later, the child likes to add toys and games that will display his mental abilities and manual dexterities. These may include such things as card games, parcheesi, checkers, puzzles, cutting out paper dolls, using carpenter tools and making mixtures with a chemistry set. Children need certain toys just as the actor needs his stage "props."

However, raw materials which are easily available and not expensive, can be put to use in any variety of ways. These prove themselves most suitable and helpful in drawing upon the child's imagination. Blocks, for example, can be a city tower, a train or the outline of a boat. Cloth material can be a blanket, a table cloth or a very lovely skirt. A carton can be a doll's bed, a garage, a theater or a wagon. With imagination much can be done with scissors, paper and paste. Crates, ropes, boards, shovels and dirt can produce a realm of constructive outdoor projects.

Elaborate mechanical toys, which are easily broken or go out of order, are not as adaptable to creative play. Their performance is limited and repetitive. They do not draw upon the child's imagination and he soon may cast them aside.

Children do not need to have a large quantity of toys, but if the selection of what they do get is properly made, they will spend many hours happily creating and constructing their play.

An interrupted time for play, the proper equipment, and an understanding person are requisites if a child is to make fullest use of play in his total development.

RESULTS OF PLAY

What can we expect children to learn through play? Children learn to use their bodies, to use their own muscles in putting themselves under power. We cannot develop a child's muscles for him; he must do it himself. A child creeps along just before he walks. He has tried repeatedly, and when he finally comes to those first few steps, he walks and tumbles, walks and tumbles; but the joy of getting around himself is not overshadowed by a few hard bumps. Once a child conquers his walk, he strives to do more. He has to be three before he can jump off the ground with two feet. He has to be four before he can skip. He has to have acquired the muscle development and coordination gained in preceding activities before he can do these relatively simple feats.

On a rainy afternoon, I have watched a three-year-old practice her skill on an old sofa. First, she jumped off the cushions to the floor. She

did this several times. Encouraged by her own success she jumped off the arm of the sofa, still successfully. She next attempted a catastrophic jump from the back of the sofa. I am not advocating old sofas as play equipment but merely illustrating that this physical activity was developing her large muscle groups and muscular coordination. We need to provide the kind of equipment that will encourage this kind of play. As a child grows older, he will swing and climb, ride a tricycle, roller skate, and play baseball. Think of the coordination it takes to ride a two wheeler!

Engaging in physical play develops muscular coordination to a progressively more skillful use of the body. The feeling of capability that the child gains through this type of play gives him more and more confidence to go ahead with new undertakings.

Through play a child learns to use his mental powers. After watching a four-year-old make clay blocks, he piled them one on top of the other. "This is my house," said he. Then a final block was put on the top, "This is the roof." A bit of pinched-up clay was put on the top of that, "This is the chimney." This beautiful bit of thoughtful construction was followed by this statement, "Houses don't have tails." This child was beginning to put the world together.

Another child attended a wedding with his mother. He was wide-eyed as the beautiful bride proceeded down the aisle. "What's that, Mommie?" as he pointed to the trailing gown. "That's the train, dear." "But, I don't hear any noise?" was his thoughtful and puzzled reply. What can we expect when there is such a maze of facts to be absorbed?

Learning which things are connected, or have relations with the other is really a tremendous process. Children begin to organize information by making observations and comparisons and noting differences, and their play materials are their laboratory equipment. They have to understand about the why, the how, and the when of things.

For the older child, we must provide materials by means of which his learning will progress. Seeds and gardening equipment, carpentry tools, thread and needle are appropriate. Sturdy equipment upon which he can depend to produce a garden or a bench is superior to toy imitations that adults think appropriate for a child's use. This type of play is often the first step in the direction of an adult activity. The joys of accomplishment are certainly a familiar story to a group of occupational therapists. Crafts. "I made it myself." Isn't it wonderful?" As simple a project as a decorated paper hat may consume an afternoon which might otherwise have been spent in sad day-dreaming or aggression. Projects for the child are simple in material and construction. Yet they can be a worthwhile asset to growth if they help a child discover that from simple materials, his own imagination and hands may construct a product of worth.

As we cannot develop a child's muscles, so it is impossible to do his thinking for him. Give him an opportunity to engage in activities that will allow him to acquire a sense of accomplishment. As he learns to construct and complete a project, to experiment and solve problems, he will become an active interested participant in his world. This type of play forwards his independent thinking.

Through play, children learn to get along with other children. Playmates are a child's first encounter with people his own age. This presents a different relationship from that which they have known from the adults who have seen that their everyday wants were satisfied. Here are people the same size who want to have the same toy he has at the same time, who want the same attention he wants. He has to learn to share and take turns. This is not an easy or natural procedure for the very young. The two-year-old cannot comprehend sharing, and therefore it is a mistake to ask them to share. All children are naturally self-centered. Only gradually do they learn to ask for things instead of grabbing. Only gradually do they learn to take turns. The three-year-old displays his recognition of learning fair play by saying, "Is it my turn to take a turn?" It takes an understanding adult near at hand to help a child over the learning bumps of sharing.

Group play comes into being at about the sixth year. Together children begin to play such things as house and store. Later they begin to play on a truly cooperative basis with their playmates, and accept the fact that their role in the group is determined to some extent by their own abilities and limitations. This develops into a truly group spirit in which the child becomes more interested in the group itself than his own individual enjoyment.

Through this progression of play interests in groups, the child learns much from the other

children. He learns what he is capable of contributing to the group through his own abilities. He learns the challenge of the give and take of life, how to wait his turn, and how to cooperate. The child learns that there are all sorts of people in the world who are available to him as friends and companions. Hence, he begins to form ideas about other people in terms of a sense of values.

In play, children learn about what adults do. They personify and imitate the people around them. First this centers about mother and father play. Children will always play momma and daddy; putting the baby to bed, cooking, and fixing the car. As their experience increases and their observations grow, they mimic the mailman, the milkman, and the fireman. In their mimicking play, they strive to do more difficult tasks and really learn what grown-ups do.

Play not only affords a means of learning, but provides an emotional release for children. It gives the child an opportunity of putting himself in the role of another person. Children are powerless compared to adults, but through this means, they can become the "boss" or "commander-in-chief." They can harmlessly play out experiences which have been theirs, let off steam as it were. I have seen an active child of twelve who had been hospitalized for over six months and on strict bed rest. He gave way to his resentment by warring with play soldiers and block-built forts. War after war, and killing after killing. He was displaying his resentment in a harmless way. No attention is to be paid to this type of play, for it is a normal, healthy outlet of emotion. In this type of release, children may live out their feelings in play what they cannot live out in reality. When the impulse is fully satisfied, they get bored and go on to another activity. Many is the rubber dolly who gets a pin in her skin to relieve the emotional feelings of the patient's many penicillin needles! It is a harmless, healthy outlet for feelings of revenge.

Play is a vital part of every child's world. Children must have all types of play to develop wholly—physical, dramatic, creative and constructive. Children are not like clay to be moulded into a certain form, but like a flower that must be watched over until it assumes its own identity. They must be treated as individuals. They must live in an atmosphere of security. Only then will they feel safe in being naturally active and in exploring new activities, and free to learn about themselves and the world in which they live.

The Paraplegic

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During the last twenty-five years great strides have been made in the study and care of the paraplegic patient. A few years ago we knew practically nothing about these cases. In fact we never heard about them. They were considered as the living dead with no prognosis. Sooner or later the normal degeneration of tissue and mind won the battle of death over life and no one held the power to arrest this process. It has been stated by Dr. Covalt that only one patient with a spinal cord injury has survived the first World War. Today approximately 2,600 World War II patients are not only alive but are being led towards independence and security.

Wounded and maimed Veterans still make dramatic copy. Life, Atlantic, Reader's Digest, Saturday Evening Post, and Newsweek, have all within the last year published articles on the Veteran paraplegic.

The efforts to rehabilitate the service injured has brought new hope to civilian paraplegics who outnumber Veteran cord cases *eight to one.* Bellevue Hospital has a rehabilitation setup to care for the civilian crippled and under Dr. George G. Deaver's capable direction paraplegic men, women, and children, are undergoing intensive training that will enable them to take their place in society as useful, wage earning citizens. The Society for Crippled Children and Adults with workshops all over the country has many paraplegics on their case loads. In one such Rehabilitation Center there was a young woman who fell from a second story window while walking in her sleep; one man had injured his spine while racing a motorcycle; one fell from a tree; another was in an automobile accident. A little girl suffered injury to her spinal cord during surgery; and still another paraplegic patient had had polio.

Despite the use of new drugs such as penicillin, and sulfa, and improved surgical methods, the paraplegic cannot be cured of his paralysis. All that can be done is to prevent further damage, prevent secondary complications, and to train around the disability. Today we refuse defeat, we are not content to let these patients lie still and die. We badger them into making the supreme physical effort to live and to get up on their feet, and we take time to keep alive a spark of hope and a desire to return again to the world as useful members of society. This is the advance treatment. The help offered is in the adjustment to the disability not in a panacea. The patient is taught development of compensatory function. He may not be able to use his lower extremities but his upper extremities are over developed to such an extent as to enable him to use his shoulders, arms, and hands for crutch walking with braces and once the patient is ambulatory most of his physical distress is obliterated.

EXPLANATION

In order to understand the disability and the complexing problems combined with the initial injury to the spinal cord it is necessary to understand the picture from an anatomical point of view.

The spinal cord is the great artery of communication. The brain responds to every wish and desire; either conscious or unconscious; voluntary or involuntary. All messages are sent from the brain to the organs or extremities via the spinal cord. If the cable is not clear or free of obstruction, unless all the nerves are free with unrestricted action of dendrites and axons the messages and impulses transmitted will not be translated into motion.

The cord may be injured in several different ways. Foreign matter such as splinters of vertebra may obstruct; hemorrhage or tumor may compress the cord. Disease may attack the fibers destroying their continuity. Trama may sever or bruise. Whatever the cause it remains a fact that all parts of the body below the site of the attack are affected. If the injury results in complete severance then no return of function can be hoped for but, if severance is incomplete or partial after some months some nerve fibers may regenerate and some return of function is experienced.

The very nature of the disability makes the treatment complex and formiable. Not only are the denervated extremities paralyzed but so are the internal organs below the site of injury. There is loss of sensation as well as loss of motor impulse. Consequently we must consider several major problems as one, all of equal importance. A full team of workers consisting of a neurosurgeon, a psychiatrist, a urologist, an orthopedic surgeon, a physical therapist and physical therapy technicians, occupational therapist, corrective rehabilitation supervisors, nurses, diet technicians, etc. all must join in full time service to these patients. The program must be intergrated. Each division must work towards the ultimate goal of self care for the patient and while all are concentrated on his physical well being they must also be cognizant of his mental health.

TREATMENT

Neurosurgery

The work of the neurosurgeon is of prime importance at the time of the initial injury. It is his task to determine the exact location of the injury, and the extent of the paralysis and loss of sensation, and to decide if surgical measures are feasible. Roentgenograms will help the surgeon in his decision and the Queckenstedt test and myelographic studies combined with the clinical picture will give exact knowledge of the level of the spinal block. Even after laminectomy and explorations of the spinal cord the ultimate prognosis cannot be stated categorically. Later when the patient has recovered muscle tone and where muscle spasm is a problem the neurosurgeon may be called upon to perform a rhizotomy.

UROLOGICAL

The urologist is of equal importance in the initial injury. He must be on constant guard against cystitis, uremic poison, and general sepsis. Dr. Munroe of the Boston City Hospital who as a neurosurgeon has worked for years with paraplegics has worked out a tidal drainage or flushing system of the bladder and this method is resorted to in most early cases. The bladder fills in two or three hours by gravity and empties in about 2 minutes time when pressure point is reached. In this manner a constant flow is maintained so that stagnation of urine cannot occur. However the patient is chained to this apparatus, so every effort is made to set up an automic cord bladder. An indwelling catheter is introduced with clamp, patient is instructed to empty bladder at intervals by release of clamp. As an aid to automatic control abdominal pressure is exerted until

bladder contracts reflexly and sphincters react. In using manual expression care must be taken not to rupture bladder. Once reflex action is accomplished patient is encouraged to set up a clock routine for micturition and he is expected to use normal toilet facilities if possible. Dr. Munroe states that only those whose bladder has been denervated because of bilateral distruction of the parasympathetic plexuses or the lower four sacral segments or roots will need extraneous aids such as a catheter or urinal to accomplish an infallible 24 hour urinary control. In drastic cases of complete cord severance at a high level a supre-public cystotomy is done which will permit drainage to abdominal dressings. This is resorted to only as a drastic means of preventing sepsis, since bladder tone is eventually lost, and the physical and social rehabilitation of the patient is a remote possibility.

Aside from bladder control the urologist must be constantly aware of the possibilities of bladder infection. Infection may be introduced by the catheter or may be caused by incomplete drainage of the reservoir. The sulfa drugs, penicillin, and streplomysin have been most effective in controlling this condition and pyelitis and urethral abscesses have reacted favorably. Calculus formation is another possibility caused by infection and stagnation. This condition can be minimized by helping the patient to change his position frequently in bed; by proper flushing of the bladder and by aiding him to achieve an upright position as soon as possible. The following hints for maintaining a healthful urinary drainage system should be followed by each paraplegic patient for the remainder of his life.

1. Drink a 10 oz. glass of liquid every hour between 7 & 7.
2. Keep an intake and output chart to guard against residual liquid.
3. Empty bladder completely every 3 or 4 hours.
4. Change position even while confined to bed.
5. Get into an erect position as soon as possible.
6. Take specimen routinely to check condition of urine.

The bowel must be considered as well. With no control an enema is necessary every third day, but if some return of function is present then the patient is set on a routine time schedule for each day. He is encouraged to avail himself of normal toilet facilities and is instructed to use gentle massage of abdomen following the ascending, transverse, and descending colon to set up evacuation contractions and he is told to concentrate on the evacuation in order to produce voluntary control.

DERMATOLOGY

Another major problem of the paraplegic patient is that of the care of the skin in areas enervated by the spinal injury. The outer protective covering of these parts will break down into decubitus ulcers in a very short time if the nurse is not constantly on guard against this hazard. There will be no pain, no sensation, in the area to warn the patient. Causes contributing to this condition are: wet or damp skin due to incontinence of bladder or bowel, skin pressure over bony prominences particularly in lower back and sides of thighs at site of trochanter, and inadequate diet, low in protein, and calories.

Prevention of ulcers and care of skin includes frequent change of position, maintaining dry clean linen free of wrinkles, bathing the parts with soap and water, drying well with gentle massage to stimulate circulation, application of alcohol for skin tone, dusting powder for absorbtion of moisture, Stryker frames, and a well balanced diet to maintain healthy skin structure. In cases where ulcers have failed to respond to ordinary treatment skin grafts are done to close the wounds.

DIETETICS

The problem of diet for the paraplegic patient is all important. The immediate loss of weight is characteristic of this particular disability. Not only must the normal weight balance be regained and maintained but the patients appetite must be tempted to encourage him to partake of a full course balanced meal in order that he may feel again the life giving energy, the will and strength to achieve the final reestablishment of independence. Diet and initiative go hand in hand as has been proven by the test experiments made by the University of Minnesota on 36 conscientious objector volunteers. The paraplegic patient must have a low alkaline diet including calories for energy, proteins for repair, and all the vitamins for general health. He must understand the necessity of a well balanced diet, and be cooperative in assuming the responsibility of consuming a full daily ration. The use of alcohol is discouraged.

Let us pause now for a moment and consider

the picture of the patient with the spinal cord injury. It is a complex tableau confused with medical and surgical problems and so far it is only a physical diagram. This patient is beset by many ills. His diet must be well ordered and metabolically perfect; elimination of fluids and solids must be watched and trained voluntary action must replace normal ejection; the bladder and kidneys must be watched for urinary sepsis and stone formation; the skin tone must be maintained to prevent the wasting away of tissue and the introduction of infection. With constant care we will now assume that the team of workers has combatted all these problems and trials which did not appear as separate contingencies to surmount; they were presented in the initial picture and were attacked as one, for the physical comfort and safety of the patient.

PSYCHIATRIC

This patient's mental and emotional adjustment must coincide with his physical treatment so that as the body repair and training advances the mind will cooperate and seek compensations in well directed channels. Just as diet will build up iniative transmitted to will, so must good psychiatric treatment aid the mind to accept and help the body in the will to do. The mind and the body must work as one because of the dependence of one on the other. Newsweek reports the psychiatric condition of the paraplegic is surprisingly good. A recent Army study revealed that 70% had achieved good psychological adjustment; 15% were strongly depressed while 12% were indifferent to recovery. Of 1,578 paraplegics under V.A. care only 83 are in neuropsychiatric hospitals. These are encouraging statistics but it has been said the normal man gets used to the abnormal faster than the physically disabled adjust to themselves. The wounded seldom voice their real thoughts. They will adjust; but mental stagnation, inertia and empathy will add to their burden unless they have an opportunity to unload their fears and doubts. The psychiatrist who will assist in the adjustment of this patient has an all important role in his rehabilitation.

PHYSICAL MEDICINE

All this afore mentioned program has been organized with but one goal in view: that of saving the patient's life and preparing him to live to the fullest physical, mental, social, vocational, and economic usefulness of which he is capable, with a fair degree of physical and mental adjustment. Now he is ready to help himself. Altho he may still be confined to bed and unable to move, his guardians who have saved his life open the door to a fuller more independent existence. The Physical Medicine staff consisting of physical and occupational therapists under the direction of a physiatrist moves into action.

PHYSIOTHERAPY

Patients are first measured for braces for support of the lower extremities. Lesions below thoracic 10 with preservation of quadratus lumborum may be fitted with walking calipers, while those patients with lesions above thoracic 10 usually have pelvic bands attached to braces of a pelvic cage used for additional support.

While these braces are being made, and while the patient is recovering physically a training program is set up to so develop the upper extremities to support the lower parts. Pre-ambulatory programs consist of massage and active and passive exercise combined with electro and hydro therapy. Emphasis is laid on development and strengthening groups of muscles used for body movement, coordination and balance necessary for locomotion and self care. The tight muscle cramps or spasms of the spactic muscles must be treated and re-education of the flabby relaxed flaccid muscle must be considered. Active exercise may be achieved in bed, in wheel chair, on a mat, and later when braces are obtained between parallel bars and on crutches. Some of the exercises concentrated on to prepare for crutch walking are:

1. Strengthening of arm flexors, used to move crutches forward.
2. Strengthening of forearm extensors to hold elbows stiff so that arms will not buckle.
3. Exercises for finger and thumb flexors, for grasp of hand bar of crutches.
4. Exercises of dorsiflexors of wrist to hold hands in good position on hand bar or crutches.
5. Exercises of shoulder girdle depressors and downward rotators to support body on crutches.
6. Abdominal and back muscles if undamaged must also receive consideration to aid in support of the trunk.

Bed exercises will relieve stiffness and prevent atrophy. A monkey bar on the bed will serve to assist the patient in helping himself and push-ups will help to strengthen the triceps, the all important extensor muscles that will

carry the bulk of the weight. As a bed patient he will learn to sit in erect position, will learn to feed, shave and dress himself.

The patient will graduate from bed to wheel chair and as soon as this feat is accomplished the patient advances to a more complete routine of self care. He can move to normal toilet facilities, can learn to manage doors, ramps, trays, and in this manner avail himself of outdoor facilities and games. He will learn to get from wheel chair to floor and return, from wheel chair to ordinary chair and return, from wheel chair to car, even before he stands in braces.

Once braces are fitted the patient is taught balance. An effort is made to develop the sensation of balance by auxilla pressure since the patient will be unaware of his feet on the ground. He may be placed between parallel bars, or a walker may be used, but a sense of balance is imperative before crutch walking is attempted. With crutches and braces the patient is taught to walk again. Several gaits are used, the step through gaits being slower but safer on slippery surfaces or in a crowd, and the swing through gaits being quicker for covering distances.

Common gaits taught are:

1. Tripod gait, crutches placed apart and slanted forward at lower ends, upper body leaning forward, feet well behind.
   - A. Tripod alternate crutch gait
     Right crutch, left crutch, drag body forward
   - B. Tripod simultaneous gait
     Both crutches forward, drag body forward
2. Swinging crutch gait
   - A. Swing to crutch gait
     Both crutches lift and swing body to crutches
   - B. Swing thru crutch gait
     Both crutches lift and swing beyond crutches
3. Four point alternate gait
   Right crutch, left foot
   Left crutch, right foot
4. Four point simultaneous gait
   Right crutch and right foot
   Left crutch and left foot

Besides gaits, patient must accomplish simple, or not so simple, tasks such as putting on braces, locking and unlocking them for upright or sedentary position. He must learn to walk backward or sideways several steps, to open and close doors, to walk up and down a ramp, curbs or stairs with and without hand rails, get down to floor and regain upright position, to walk carrying a valise, to cross a street with the traffic light, to walk at least a mile, and to drive a car with manual control.

OCCUPATIONAL THERAPY

Primarily the physical reconditioning processes are directed by the physical therapist. However as the patient progresses each day his new accomplishments are carried over into constructive tasks under the direction of the occupational therapist. It is all very well to encourage the patient to get out of bed, but where is he to go once he can walk out of the ward?

Actually the work of the occupational therapist begins immediately the patient is in a condition to accept reality. At first her object may be simply to interest the patient in diversional activities such as objective conversation about news, books, hobbies or music. Later she may lead the patient's interest towards reading or into learning a simple craft. As soon as she receives orders for functional treatment she will attempt to incorporate her patient's interests into crafts where he will gain increased strength of the muscles that require development. A bed loom may be suspended from the monkey bar and the patient by throwing the shuttle over and back across the warp, and by manipulating the heddles for change of shed may gain extension, flexion, abduction, and adduction of arm as well as shoulder development and flexion and extension of fingers and wrist action, all motions which aid in strengthening parts to be used in ambulation.

Once the patient has graduated to a wheel chair he can of his own volution come to the occupational therapy workshop. Here functional work will again concentrate on the shoulder girdle, the forearm, wrist, and hands. He may work in the carpentry shop, his project placed at a high level or in a vise he can reach only by arm extension; he must grasp tools of various weights and sizes, thus using finger extensors and flexors, and even back and abdominal muscles receive some exercise as he reaches, lifts and twists in his chair.

As soon as the patient can use crutches, and is striving for strength and balance he can stand in the workshop, using a bench for support if needed. By moving around the shop procuring tools, wood, glue and nails, necessary for his

work he will practice his gaits. His confidence in himself will grow as he overcomes each new venture and work tolerance will increase daily. A busy workshop presents most of the hazards and contingencies of daily living.

The physical therapy and occupational therapy departments caring for this patient must be so integrated that each is cognizant of the others activities. It matters not just where the patient finally adjusts and becomes independent of his surroundings. What does matter is to have a patient who is well adjusted both physically and mentally and who is independently ambulatory.

All this is an ideal program but how can the patient's interest be held during his long months of convalescence? This convalescent period is frequently interrupted by physical breakdowns and emotional disturbances. The patient is often a victim of dispair despite the efforts of the whole corp of workers to help him in emergencies. The technique is to keep this patient interested, to keep him dreaming and planning some future day of accomplishment. He has been reclaimed mentally and physically, now he must face reality and return to society.

First it must be realized and accepted that any work this man may choose for the future must of necessity be labor that he can do with his hands and mind. Of course he will be able to walk, but he cannot dream of earning his living as a milkman or a postman. He can however if he is interested in dairies be a chemist guarding his fellow citizens against impure milk; he can if he is interested in postal work sit at a window of a post office, selling stamps, weighing and insuring parcels, writing money orders or sorting mail for the man who will deliver it.

So it is important to evaluate the man's aptitudes, his education, and intelligence quotient. What does *he like* to do? What is *he best fitted* to do with his inherent and acquired qualities, and what *can he do* are questions to be considered and answered. Diversions, hobbies and recreation are fine things in their place but sooner or later the problem of "How am I to earn a living" faces the paraplegic patient.

There is of course always the possibility that a man may return to some branch of previous employment. Often it so happens that the patient's former occupation is not feasible or that he is not willing to take a less active position in a familiar atmosphere. This is understandable because the man is forever haunted by the past, he is reminded constantly of his former physical self and activities and he shies from the ghost.

If a man receives a pension or compensation for injury he may be inclined to think this amount sufficient for his daily needs and decide there is no need for him to work again to earn a living. In this case it will be necessary to instill in each patient the belief that although he has been unfortunate in the interruption of the pursuit of life, he must of necessity evaluate the powers left to him and these powers must be used for his own benefit and for the wealth of the community. For the unemployed not only do not produce, they consume the gains of other workers. Society owes the individual the right to live but each individual no matter how limited in capacity has his debt to society. Pensions make good lap sitters but the cushion will wear thin.

Milton Lehman in an article published in the Saturday Evening Post described Ward 13 in the Bronx Hospital. This ward is inhabited exclusively by paraplegics. He states that by act of Congress these men are entitled to remain there for the remainder of their lives. They receive a total disability pension of $360 a month. They possess and drive hand operated cars provided by the government, they have their own newspaper and softball team, their own Paralyzed Veterans Association. A few have graduated to the outside world. Two to the Columbia University School of Journalism, another to the Bulova Watch School, but most are content to remain in their comfortable familiar surroundings. Who is to blame for this condition? Are we making life too comfortable for these men or is it that we are failing to prepare them for the realities of every day living? How can we stimulate them into starting over with their residual disabilities?

Recently it was discovered in a booklet put out by the Universal Handicrafts, Inc. called *Creative Ideas,* describing work done by patients during a convalescent period in a hospital, that 12 out of 15 patients recorded wished to continue craft work. Several patients recorded that they would earn a living in some other manner until craft work was better paid. It is easy to understand why craft work was chosen. The occupational therapist and craft teachers employed by the hospitals are teaching such patients crafts because it is part of their curri-

culum. Are we not blind to the manifold opportunities outside the field of hand craft work? What about the patient who is not gifted in art? Should he string along copying ideas hoping to find a sales outlet for second class goods in a field already overcrowded with knick-knacks? When a patient is doing simple leather lacing for diversion, while still confined to bed is it not possible to develop in him a spark of interest in the kinds of leather obtainable; in the various methods of tanning and processing leathers; and in the new simulated leather? Is it not possible to broaden even this narrow interest into geographical, historical, and biographical information concerning this material? Perhaps by the pursuits of these activities the man may become an authority on leather, its uses and its history. A simple diversion of this kind may lead to a good position with a firm dealing in leather goods. Some one has to interview the salesman, some one has to evaluate the markets and watch the fluctuation of prices, why not your paraplegic patient. He can drive his own car to work, walk from parking space to door, and go up an elevator to his office. Sitting at a desk who is to know this man with the powerful shoulders has no control of his lower extremities?

If a man shows an aptitude for weaving need that interest be limited to weaving on a loom? The scope can be widened to include testing of materials and a study of drafts and patterns. If proper contacts are made we will find the research laboratory of textile corporations eager to hire this man.

Perhaps a man has a flair for drafting. He need not aim to be an architect where competition may be too keen for his talent or his strength. He can however engage in making layouts for floor space for local stores, and for seasonal decorations. He can plan window displays and special feature counters.

The local printer may discourage your paraplegic patient in his interest in printing. Perhaps he will say we can use him to run a linotype machine if he can stay on the job but it is doubtful if he can sit on a hard stool for a full day's work or move around in the restricted space between machines. However if your patient will learn type faces, fonts, and the art of job layout, then he will not only be of value to the printer but he will be assured of good working conditions and a good livelihood. The layout takes more time and real talent than the actual setting of type and the printing on the job.

We stated before that the goal is to keep this patient dreaming and planning. Let us add to that statement. Can we not challenge this patient into new fields of accomplishment?

Have you ever wondered why no one has ever put a hand brake on a wheel chair? Who would have more interest, more right for a patent than a paraplegic patient?

The paraplegic will wear leg braces for the remainder of his life. He must learn to care for these braces, leather must be oiled to keep it soft and pliable, metal must be kept free of rust, and joints must be oiled. When an appliance is part of a man's dress can he not be led to an interest in the making of these and similar braces for others in need of such support. The market is flooded with orders and all will agree there is room for improvement in construction and choice of materials. Who is more fitted to devote his time to this work than the man who so depends on them?

Most brace wearers need special shoes. Thousands of others need shoes built for congenital or acquired malformations of lower extremities. These shoes are difficult to obtain and they are very expensive since few are trained to interpret a physician's prescription. Here is another field for the paraplegic. The fundamentals of shoe repair can be approached as primary training and later actual shoe construction can be learned.

These three small suggestions are primarily for one reason, they are of interest to the patient at the moment. Wheel chairs, braces, and shoes are part of his world and he understands them and their importance to him. If the patient deliberately closes his mind to things in the outside world he feels he can never again obtain he is more apt to concern himself and show interest in the necessities of the present.

Our job then is to present a distinct challenge, a specific plan for a gainful occupation. The Boston Traveler (May 5, 1948) published a picture entitled PLUMBING TOOL INVENTION. Harland Jones, a Seabee veteran convalescing at the Birmingham Administration hospital in San Fernando, Calif., invented a pipe-reaming tool that fits in the center on the open end of a conventional pipe threader. It cuts out the burrs left by the threader. He is one of several veterans inventing while convalescing. Jones has already patented one tool

which is being manufactured and on which he receives royalties.

Most occupational therapy shops will have some tools that can be used in these trades and little additional equipment would be necessary for the work involved

But you will say "How am I to teach these trades?" The answer is you don't need to. No one expects an occupational therapist to be a brace or a shoe maker but somewhere in her own locality she can find some one who will be willing to give some time for instruction. The local shoemaker will be glad to co-operate and the firm that makes the braces for your patients will be eager to assist these same patients in learning the trade because they are most anxious for help.

This suggestion will of course start a controversy as to just where the occupational therapy program begins and ends. As far as the writer is concerned the occupational therapy program is as wide as the therapist's own horizon. A good supervisor is one who supervises. She plans detailed programs for the rehabilitation of her patient under a physician's orders, first perhaps for diversional therapy, then for remedial functional activity, meanwhile evaluating the patient's aptitudes, work habits, work tolerance, social adjustment and co-operation. It is the occupational therapy program that will prove the worth of all the previous treatment because here the patient will carry over his physical reconditioning his instruction in physical therapy and his mental adjustment to his disability. Arts and crafts are the natural media for occupational therapy but have no right to stop with this media alone. The program can be as broad as every occupational analysis, as broad as every book in a public library and as interesting as each individual in the community. As supervisor we have to sell the job to the patient, we expose him to the written information available and we contact those who can be of assistance to the patient in his search for knowledge and skill. We need not be involved in each minor operation.

If we were to set up a hospital orchestra would it be necessary to know how to play each instrument? Of course not. It would be necessary to know what instruments we need for the type of music we want to play and it would be expedient if we had some talent in conducting and choosing production. The ability to impart enthusiasm for the project, the skill in choosing the participants and the talent to lead people to play together are attributes more valuable than detailed knowledge of each instrumental technique.

Man groped his way thru the processes of evolution to the civilization we have today. Difficulties were a challenge. He thrived on adversity; he lived conquering disaster and opposing calamity. Our paraplegics may be the superman of our race today. Their physical difficulties can be recognized as assets and as spurs to achievement. In the world of sports a handicap denotes superiority. Let the paraplegic be proud of his handicap and prove his sovereign power. He must not bewail the man he used to be, he must concentrate on the man he will be. The wealth of a country depends on its man power assets, not on its liabilities and the paraplegic can and should contribute his share of talents. All of us working in the rehabilitation team are responsible for the ultimate physical recovery and the mental adjustment of the paraplegic. But our task is incomplete, our job not done, unless we have opened the door for a life of gainful occupation for a patient inbued with faith and hope in the future.

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There is nothing an occupational therapist won't try in the interest of the profession—now it is spinning angora wool. The California Angora Wool Growers association demonstrated the art of angora spinning to members of the occupational therapy department at the University of Southern California. They are planning to evaluate the spinning process on patients suffering from orthopedic disabilities, and psychiatric conditions.

Occupational Therapy in the Management of Poliomyelitis

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1. Early Acute Stage
   a. Psychological
2. Subacute Stage
   a. Hospital adjustment
   b. Posture—in bed
   c. Restoration and maintenance of morale
   d. Maintenance of physical efficiency of unaffected part
   e. Functional treatment and aid to muscle power and strength of affected part
   f. Developmental guidance and evaluation
   g. Activities in bed
3. Convalescent Stage
   a. Carry-over of same principles of hospital adjustment, morale, physical efficiency, functional treatment, etc.
   b. Posture—sitting up
   c. Use of slings, lapboards, built-up arm rests
   d. Activities if sitting up
4. Chronic Stage
   a. Psychological problem with permanent handicap
   b. Treatment following surgery
      1. Psychological
      2. Functional
      3. Follow-up after discharge
   c. Prevocational exploration
      1. Complete records on patient
      2. Guidance of all patient's activities
      3. Close study of patient's personality
5. Time Set for Occupational Therapy Treatment
   a. Daytime
   b. Late afternoon and evening
      1. Lighting
      2. Need for services of a qualified therapist.

PHASES OF POLIOMYELITIS

The medical profession speaks usually of three stages in poliomyelitis—acute, convalescent and chronic. So far as occupational therapy is concerned, for the present at least, it seems wise to divide the acute stage into early acute and subacute.

In the early acute stage of poliomyelitis it has been assumed that occupational therapy is not applicable. Actually there are no real grounds for this assumption. The acure symptoms last only a few days, and if the involvement is in the lower extremities only, the patient is still free to use actively the upper extremities, and is encouraged to do so, according to present day treatment procedure. Isolation lasts two weeks, but even here the occupational therapist is not prohibited, for she knows isolation techniques. She receives such instruction during her training and practices it while treating other illnesses during the isolation phase. The same procedure holds for poliomyelitis. From the very beginning of illness, whether the involvement is confined to one or more anatomical sites, the occupational therapy treatment of the patient, psychologically, should and can be applied.

In the subacute (and early acute) stage, one of the first problems to be considered is *hospital adjustment.* This is true for both child and adult.

The child, even though he may have spent two or three weeks in the hospital, may still be homesick, fretful and cry easily.

The adult is fearful on learning that he has poliomyelitis—fearful as to the future and wonders, "Will I be a permanent cripple?" "Perhaps I will never walk again." "How will I provide for my family?" "Who will take care of my home?" Well may they be fearful for it is a time of uncertainty. Some, at first, become so despondent that they have been known to say, "I wish I were not living."

On the other hand, there are those who are

apathetic and will say. "If I have poliomyelitis, then you will have to take care of me." They are rather inclined to look for pity, and since Mr. John Q. Public is more aware of the disease today, the poliomyelitis victim receives more sympathy and support than ever before. We have had patients make the remark, "Well, if they want to do everything for you, let them do it."

To occupy the mind of such a patient therapeutically takes careful handling. The occupational therapist, aware of such problems, helps the patient do what he is able to do for himself to regain and retain all possible independence and self respect.

CHARTS FOR MOTIVATION

It was for this reason that we established the Daily Living Chart (adapted from the Institute for the Crippled and Disabled, New York). Some of our adult patients were not making the best progress, for they were not making any effort to help themselves. Some means of motivation was essential. Of course the chart itself would be useless without the necessary means to do the acts which were called for. Searching, making, choosing and assembling the special equipment was a big task in itself. At first, none of the patients were sure just how many of the activities they could do; some admitted that they would never have thought of trying. The suggestion seemed good to them, and if they did the acts poorly the first time, they had something to work for. In adaptability, the chart has proved to be more valuable for adults than for children, and though planned primarily for poliomyelitis patients, we have used it in the treatment of other conditions with satisfactory results.

TREATMENT FOR BED PATIENTS

Another part which occupational therapy can play in the treatment of the poliomyelitis patient is assistance in maintaining good posture. Since the patient during the subacute stage spends most of his time in bed, let us consider the bed patient.

We know what the prescribed position should be—to lie flat on the back with feet resting against a foot board, a rolled towel under the knees; or, if lying on the face, the toes dropping over the edge of the mattress at the bottom. These positions are difficult for anyone to hold, and particularly the child who is restless from inactivity and who, after the pyrexia subsides, begins to feel quite well. Even during hot pack treatment it is laborious for some patients to remain in good posture, yet if this is not maintained musculo-skeletal deformities are likely to follow. We are told that except for atrophy and weakness, deformities have just one cause, namely, persistent faulty alignment of bodily segments, which may be due to faulty beds, resting on the weakened extremities, weight of bedclothes, pain, and restlessness. Occupational therapy can help some of these situations by keeping the patient more at ease while working on his various projects. Truthfully, there is no point in putting a patient in proper alignment if five minutes later he is away from it. While working with the patient the therapist can keep an eagle eye on this part of the treatment. Of course, she must know what special position has been prescribed by the physician for each individual patient.

In the beginning stages occupational therapy activities should be limited to those that eliminate the motion of any joint where spasm occurs. If the lower extremities are involved, the hands and arms unaffected, then beginning activities should be confined to the upper extremities. This can begin even in the early acute stage. If the muscles of the shoulders are involved, but the arms and hands are reasonably strong he can still carry on interesting activities which will eliminate restlessness and prevent him from falling away from proper alignment. A well planned program must be prepared for each patient, regardless of whether he be child or adult.

The maintenance of morale cannot be overstressed. Provision must be made for interesting and stimulating substitutes for the patient's normal activities. To be sure, they are substitutes, therefore they must be individualized and organized if they are to be for the benefit of the patient. It is impossible for any able-bodied person to foresee or measure the social-emotional embarrassments which the poliomyelitis victim experiences when deprived of his active and normal way of life. Therefore guided purposeful programs and activities are necessary for both adults and children. The more they can be participators, rather than onlookers, the better.

Maintaining physical efficiency means of course, efficiency of the unaffected part which can become weak and uncoordinated through lack of use. While aiming to prevent deformi-

UNIVERSITY OF ILLINOIS HOSPITALS

Department of Physical Medicine

Orthopaedic Occupational Therapy Section

Name_____ Age_____ Hospital Number_____

Diagnosis_____

SCALE FOR RATING
FUNCTIONAL DEMANDS FOR DAILY LIVING

	Date	Date	Date	Date	Date	Date	Date	Comments
TOILET ACTIVITIES								
Going through motion of:								
1. Combing hair								
2. Brushing teeth								
3. Washing face								
4. Washing behind the ears								
5. Washing hands								
6. Filing nails								
7. Shaving								
EATING ACTIVITIES								
1. Eating								
2. Cutting meat								
3. Drinking milk								
4. Spreading sugar on dessert								
5. Stirring a hot drink								

Adapted from:
Institute for the Crippled and
Disabled, New York

Scale: Unable 1
Poor 2
Fair 3
Good 4
Excellent 5

HAND ACTIVITIES	Date	Date	Date	Date	Date	Date	Date	Comments
Going through motions of:								
1. Writing name								
2. Opening envelope								
3. Removing letter from envelope								
4. Unfolding letter								
5. Folding letter								
6. Sealing envelope								
7. Drawing straight line with ruler								
8. Dialing 'phone number								
9. Picking up 'phone receiver and putting to ear								
10. Opening zipper on dress								
11. Closing zipper								
12. Fastening belt								
13. Tying shoe strings								
14. Lacing shoes								
15. Tying tie								
16. Fasten grippers								
17. Fasten snaps								
18. Fasten hook and eye								
19. Operate pull light								
20. Operate flip light								
21. Operate rotary light								
22. Winding watch								
23. Buttoning shirt or dres								
24. Unbuttoning								
25. Washing stockings								
26. Polishing shoes								
27. Cutting along line with scissors								
28. Screwing								
29. Unscrewing								
30. Turning door knob								
31. Hooking screen door								
32. Operating switch								
33. Ironing with light weight iron								
34. Opening desk drawer								
35. Turning on faucet								
36. Lifting tray of dishes								

UNIVERSITY OF ILLINOIS HOSPITALS

Department of Physical Medicine

Orthopaedic Occupational Therapy Section

Name_____ Age_____ Hospital Number_____

Diagnosis_____

SCALE FOR RATING DEMANDS FOR DAILY LIVING

	Date	Date	Date	Date	Date	Date	Date	Comments
LOWER EXTREMITIES								
1. Sitting on edge of bed								
2. Getting on wheelchair								
3. Getting from chair to bed								
4. Standing at bed								
5. Taking first step								
6. Getting from wheel chair to toilet bowl								
7. Getting from toilet to wheelchair								
8. Walking forward 5 steps								
9. Walking backward 5 steps								
10. Moving from wheelchair to bathtub								
GENERAL ACTIVITIES								
1. Sitting up in bed								
2. Turning over in bed								
3. Moving from place to place in bed								
4. Manipulating bed pan								
5. Taking off pajamas								
6. Putting on pajamas								
7. Wheeling own wheelchair								

Adapted from:
Crippled and Disabled, New York

Scale: Unable 1
Poor 2
Fair 3
Good 4
Excellent 5

ties in one extremity or muscle group, there is no reason why the patient cannot be helped and encouraged to retain the muscle power which he never actually lost in the other extremity. Treatment for physical efficiency should be given for three reasons; (1) To restore and maintain the normal joint mobility, (2) To assist circulation, (3) To stimulate the patient's awareness and assurance that he has normal motion in the unaffected part. Physical efficiency can be maintained while in bed, and it is of greater benefit to the patient to carry on an activity for this purpose which will produce a visible and tangible end result.

When ready for active treatment, although still in bed, a program can be chosen and followed which corresponds to the line of motion the patient is doing actively in physical therapy. We cannot overlook the fact that "if active use of a part is necessary for return of power and function, then occupation is the best stimulus to active use." The active exercise for an affected part can be in the nature of manual activities which carry over into normal activities of life. Muscle re-education acquired by exercise alone is not always sufficient to carry over, and there is no particular advantage in being able to flex the shoulder to 120 degrees if this action is used only for formal exercise. If the patient has gained the power through exercise, he should also be able to transpose that power into new muscular habit patterns, even in bed, that carry over into daily use. The therapist must choose an activity according to the patient's needs so that the weak muscle is strengthened but not its strong antagonist, otherwise all coordination gained through muscle re-education is likely to be lost and the functional capacity of the whole involved segment handicapped.

There is need for a close relationship between the physical and occupational therapy departments; first, as to timing the patient's work for the day in each section; secondly, to prevent too much overlapping of the same type of treatment; and thirdly, so that each department will know whether the formal activities have been carried over into more normal functions. To treat adequately in any section requires guidance from the physician. He interprets the patient's needs, and unless his orders are clear cut, the therapist is at a loss and more or less gropes in the dark. The orders can be brief, but definite.

With the child we have the question of developmental guidance. He is at the growing and learning age—the age of impressions. His mind still develops. The more stress we can put on his normal development during illness, the more normal he will remain, in spite of his handicap. A rare opportunity exists here for an intensive developmental evaluation and guidance program with children who have been stricken with poliomyelitis, for these patients usually have a prolonged period of hospitalization.

CONVALESCENT STAGE

In the convalescent stage there is a carry over of the same principles of treatment as to posture, morale, physical efficiency, and functional treatment. Usually the patient is ready to sit up or start walking. If sitting, posture is very important. The feet should be supported with foot boards, rather than dangling three or four inches from the floor, to avoid foot drop. We have in our unit five foot boards for this purpose. They are constantly in use. There is also the use of slings for the arms. With them, patients with shoulder involvement have been stimulated to carry out many routine activities, which would otherwise have been impossible or accomplished through faulty mechanics. We know that hiking and pushing the shoulder forward in an attempt to abduct or forward flex the arm indicates improper use of the upper trapezius, pectoralis major and minor and the serratus anterior. If there is a marked winging of the scapula on raising the arm against gravity there is undue stress on the weak serratus anterior. If the deltoid is involved, there are any number of limited motions. These are a few of the situations which we look for if the patient comes to the unit without the overhead sling, and they are indications to the therapist that the patient should use the sling when working, at least to strengthen the arm and hand. Lapboards and adjustable tables also fall to the lot of the occupational therapist to develop and adapt, as well as built-up arm rests, so that patients can feed themselves while seated in a chair.

There are many adaptations possible in activities and projects to help in maintaining physical efficiency, or to provide an aid for muscle power and strength, while sitting up. However, to make a complete analysis of any one of these would cover pages.

CHRONIC STAGE

Three factors are prominent in the treatment of the chronic stage of poliomyelitis, namely: A. Psychological adjustment; B. Treatment following surgery; C. Prevocational exploration.

A. Nearly every patient must be helped to adjust to a permanent disability, to live with his handicap, to overdevelop within his potentialities. We all must remember that the ultimate success of any treatment depends not only on the physician, the physical or occupational therapist, but the patient as well, and the parents. Not only do we have the task of trying to improve the physical condition, but also the mental. We must help the patient feel that a weakened muscle does not mean defeat. Improper attitudes on the part of a patient or his family may lead to maladjustments of personality that will be even greater handicaps than the physical disability. On one occasion in the hospital a patient was asked why she didn't do a certain act which she was able to do. She replied, "Well, you know, I've had polio." The physically handicapped are too frequently inclined to assume habits of idleness, because they cannot always participate in the activities of others. This is all the more reason for a planned stimulating and motivating program for them.

B. Treatment following surgery includes both the psychological and the functional aspects and the follow-up at home. It is a known fact that some patients, following surgery and reeducation, have the power to use a muscle group but an extreme sense of fear hinders the progress. Sometimes this fear can be minimized or eliminated through activities which are interesting to the patient. It is also known that patients have lost valuable muscular control and power from disuse after discontinuing muscle reeducation. Perhaps if the muscular control had been carried over into more normal activities, this would not have happened. This then leads us to the patient who is discharged from the hospital, for invariably there is a great need for a follow-up program at home, so that the muscle reeducation gained, is retained and used.

C. With regard to prevocational exploration, the occupational therapist plays a valuable part, for all through hospitalization she has a chance to observe the patient—his abilities, interests, skills, attention span and strength, all of which serve as a guide to the physician, the vocational rehabilitation agencies, instructors and employers. This calls for: (a) Careful recording; (b) Well planned guidance of patient's activities; (c) Careful study of the patient's personality.

To effectively treat poliomyelitis there must be a set time for the program. This is not a job for one department; it is a job for many and if it is to be well done, each department must have its set time to do its work, and must be aware of what is being done in each section so that the whole program is planned and synchronized to the best advantage of the patient. In some hospitals the best laid plans are often thwarted because of poor timing of the whole program. When this occurs, rechecking is necessary so that the full line of treatment is carried through daily.

The possibility of a program for these patients in the late afternoon and evening might be studied. This is the time of day when there are not so many rounds, fewer activities and the general commotion has subsided. Yet the patient has polio and still needs care. Patient care is not just an eight hour job—it's twenty-four. A gap remains between the preparation for the evening meal and retiring hour when the patient often is alone. The evening for many patients seems long, and if a patient is restless, this can often be carried on into the night. One patient thought that she had to be turned every fifteen minutes during the night. A patient in the next bed, who had been in the hospital for weeks and who never previously thought of this, developed the same idea. Consequently, the night nurse had a vicious circle on her hands of which she was the victim. Activities were left by the therapist for these patients to do themselves in the evening, but there was no one to motivate them to carry on, and usually they did very little.

The late afternoon and evening offers the therapist a real opportunity to make use of the Daily Living Chart—observe the patient, for example, at the evening meal, to see how much he can do for himself. To provide stimulus she could carry on a very different program from that of the day. It would be wise however, to consider two vital factors. First, the importance of good lighting on the wards. Too often the hospital wards are equipped with poor lights. Secondly, the late afternoon and evening work must be considered the responsibility of a trained therapist who comes on duty at this time regularly with a planned program of treatment for her patients, which she carries through

systematically, so that there is no lack of continuity or efficiency.

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Co-operative Occupational Therapy and Casework Service in Treatment of the Mild Psychoneurotic Patient

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The writers are employed at the Convalescent Home of the McGregor Health Foundation in Detroit, Michigan. The Foundation was developed and financed by Tracy W. McGregor who was interested in helping to restore men and women, previously in active life, to full health or to their maximum efficiency in partial health. Patients who are convalescing or in need of rest care and whose physicians believe they will return to useful activity are eligible for admission. This includes convalescents from organic illness and mild functional illness, but excludes the acutely or chronically ill. Each patient must have the services of his own physician. A physician and a psychiatrist are engaged by the Home, each for about an hour a week to act as consultants to the staff. The regular staff includes a graduate nurse as superintendent, nursing personnel, a trained dietician, registered occupational therapist and graduate caseworker.

CO-OPERATIVE EFFORT

Both occupational therapy and social casework represent recently developed skills which are finding a place today in the constellation of specialties working side by side in treating human ills. For the past twenty-five years these professions have been forging ahead, evolving philosophy and definite techniques in their fields. Yet few practitioners in the two groups know very much about each other's aims and less about the relationship they bear to one another.

Just prior to 1936 there were only five approved or accredited Schools of Occupational Therapy in the United States and Canada. On an average they graduated not more than fifteen students per year, after completion of three to five years of study. This was obviously a mere handful as compared to the number of social caseworkers coming out of accredited schools throughout the country at the same time. The instances, therefore where both were employed on the same staffs were comparatively rare. However, World War II brought with it a need for occupational therapists to serve in government hospitals. Accordingly, an accelerated training program was inaugurated. This increased the number of schools in 1945 to twenty-one, seventeen of them accredited. Thus the war years saw growth in the number of trained occupational therapists in the field. Although most of these are still in the government hospitals which so avidly recruited them, they are gradually filtering through to private hospitals and sanatoria for the care of the physically and mentally ill, schools for special education, homes for the aged, private industry and insurance company rehabilitation workshops. Here, they are beginning to rub elbows with caseworkers who have preceded them by only a little. Wherever the special skills of the occupational therapist and the caseworker are both employed in the interests of service to the individual, there is a fertile medium for experimentation. They must learn how best to expand one another's understanding of their respective goals, how to achieve cooperation, and how to coordinate effort in keeping with the highest professional standards.

The following material describes the experience of one trained caseworker and one trained occupational therapist, both of whom were well oriented in the mental hygiene field, during a nine month period in which they were employed in a small convalescent hospital. Neither service had heretofore been available to patients, although there was a professionally untrained

diversional worker on the staff for a number of years previously. Therefore, it was encumbent upon the two to organize their own departments and develop their own teamwork. Though probably not all the techniques developed in this setting would be applicable in other places, certainly they might in some degree stimulate practitioners in the two fields to see possibilities within their specific environments.

The Convalescent Home of the McGregor Health Foundation is a forty-five bed hospital, housing patients in two buildings located on two acres of ground. As the institution is at this point experimenting and, therefore, functioning according to an undetermined policy of intake, both convalescents from organic and emotional illnesses are accepted. Men and women are both eligible for brief periods of care ranging from one week to several months. Irrespective of category, however, the governing ideal is the care of the true convalescent whose prognosis indicates hope of return to useful activity in the community. Because the occupational therapist and caseworker are new on the hospital staff and represent services with which some doctors are unfamiliar, and because they are not routinely making contacts with physicians about patients at the time of referral, their services are frequently not incorporated in the treatment program of the patient on admission. The occupational therapist and caseworker must at present try to learn for themselves the needs of most patients after admission and how they might be of help. They then offer their services to the doctor. Perusal of the nursing charts, observation of patients, and friendly approach whenever there is a natural entree are among the techniques used.

Inasmuch as case work is for the present being directed primarily towards the rehabilitation of the emotionally ill patient, the conclusions reached emerge from efforts to integrate casework and occupational therapy as directed to particular patients in this group.

TECHNIQUES

To understand how these two specialists were able to work cooperatively, let us first consider briefly the aims of each in therapy. Both are primarily interested in the recovery of the patient, but each has distinct contributions to make in the total program of medical treatment. From the medical or psychiatric diagnosis and prescription, occupational therapy and social casework receive their direction and become adjuncts to treatment and to the clarification of prognosis. The occupational therapist endeavors to activate the patient's potentialities for self expression, either aesthetic or practical, to aid in the reconstruction or improve the coordination of impaired mental or physical functioning. Properly prescribed and directed activity comprises her tool. The caseworker attempts to help the patient harmonize the environmental and emotional factors affecting his life so that they may exercise a positive influence on his recovery. Through the medium of interviews, in the course of history taking and regular mentally therapeutic contacts, and by harnessing available community resources, the caseworker seeks to obtain results.

In a setting as small as that of the Convalescent Home, where contacts between staff members can be frequent and informal, it is possible to keep one another aware of the behavior of patients and their progress under treatment. Probably in larger hospitals such exchange of information could best be achieved in staff conferences, through record notes, or interdepartmental memos.

The caseworker at the Convalescent Home is a link between the patient and physician. Usually, the latter is available for visits with the patient only at regular intervals. Particularly with the emotionally ill patient there are often periods between, when he feels the need to discuss his problems. Thus, the caseworker sometimes acts simply as an understanding listener—a safety valve—until the psychiatrist is again available At other times, depending upon the nature of the case and the psychiatrist's assignment to the caseworker, she participates actively in interpreting to the patient aspects of the problem. Equipped with a background of full training in casework, with good orientation in psychiatry, and previous experience in a psychiatric clinic, the caseworker in her role at the Convalescent Home has the opportunity to work closely with different psychiatrists and develop further her own psychotherapeutic techniques.

The occupational therapist has the chance for a unique type of observation. She is the one who sees patients in group situations. Hers is apt to be a frequent contact. Because the environment of the occupational therapy shop is informal and the patient need not be on guard, he is likely to bring about important material. If the occupational therapist is alert to the

significance of social, economic, and emotional factors in their effect on the patient's recovery, she can refer the patient for social services in these areas. For example, patients may bring out worries about home conditions, about the children, about money, about marital relationships, fears about their illness, their treatment, attitudes about their doctor. If, in the occupational therapist's judgment, the patient needs help with such problems, she can discuss the case with the social service department. Of course, the caseworker obtains from the doctor or the psychiatrist permission to work with his patient, or if the problem is one which he himself should handle, she merely brings it to his attention.

On the other hand, in situations where the caseworker has the initial contact with a patient newly admitted or convalescent care, and where the rapport established enables her to understand the patient and his problem, she can often recognize a need for occupational therapy. Perhaps the patient is under such emotional stress from grappling with his problem that he needs an outlet through activity. Perhaps he is so disinterested and preoccupied that he needs the stimulus of group association. There is obvious therapeutic value in having the occupational therapist help him to complete some piece of work. There have been instances at the Convalescent Home in which the doctor, not sufficiently familiar with occupational therapy, or at the time of referral not thoroughly familiar with the patient, did not include it in his prescription. However, sometimes after the occupational therapist and caseworker have had a chance to study and discuss the patient's needs and the therapist had brought it to his attention, he has been eager to give a prescription for activity.

CASE STUDIES

A brief discussion of a few specific cases will demonstrate how the methods just discussed were actually applied.

How the Occupational Therapist's Observations Were of Importance to the Doctor and Social worker.

Jane B., a nineteen year old girl suffering from a severe psychoneurosis, was under a psychiatrist's care. The latter felt that complete recovery from her illness would not be possible unless separation from her parents could be achieved. Jane was apathetic, withdrawn and related to people with difficulty. The psychiatrist wanted the caseworker to try preparing her for employment and helping her secure it. The occupational therapist observed Jane both when she was at work and when her parents visited the workshop. As a result she was able to bring to staff meeting material which demonstrated the adverse effects and the strength of the parents' attachment to Jane. These facts plus the things learned about Jane's work habits and her relationship to others in the shop were of help to the psychiatrist in predicting the outcome. It also helped the caseworker in her effort to carry out aspects of treatment assigned to her.

How Social History Assisted the Occupational Therapist

Alice R. was also under a psychiatrist's care for an emotional illness rooted deep in poor family relationships, but precipitated by a romantic disappointment together with maladjustment in work. She was sent to the Convalescent Home for rehabilitation through employment and for help with other living arrangements. This patient was introduced to weaving in the occupational therapy shop. She resisted it, disliked it and began avoiding the shop. The social history supplied the clue. The patient had been engaged in factory work, in an operation which was sufficiently akin to weaving that the latter called forth unpleasant associations. Teaching her to knit was substituted and the patient enjoyed it and mastered it. Her good relationship with the occupational therapist was utilized to its fullest at the point when the caseworker had the patient ready to review typing in preparation for an office job. The patient was able to experiment with her physical endurance and take tests under the direction of the occupational therapist. Her skill and self confidence were sufficiently restored that she was able to take a job and hold it.

How Occupational Therapy Helped the Patient Maintain Emotional Equilibrium During Case Work Treatment

Grace K. was herself not actually ill. She was completely exhausted from coping with a difficult family situation. Rest for herself and support and help in working out her social problem were recommended antidotes for which her psychiatrist sent her to the Convalescent Home. While the caseworker was helping Grace work out the commitment of her mentally ill mother to a State Hospital, occupational therapy was instrumental in helping her maintain emotional balance. Grace was very creative and artistic and got satisfaction through expressing herself in painting. Work done in the occupational therapy shop seemed to provide her with the opportunity of doing something satisfying at the same time that necessity forced her to do something very disagreeable. She found forgetfulness from her problem while engaged in concrete and challenging activity. From the approval of the occupational therapist and the support of the caseworker, Grace, who was losing her own mother, obtained some substitute mothering during a difficult time.

How the Occupational Therapist and Caseworker Obtained the Doctor's Permission to Include Occupational Therapy in Treatment

Dr. X. had recommended that Mrs. L. spend a month at the Convalescent Home. She was depressed and insecure. Her husband and she, during fifteen years of married life, had lived with her sister and brother-in-law. The patient's sister assumed major responsibility for the household. Mrs. L. had become increasingly dependent upon her and upon Mr. L. Of course, at the point when the L's moved into quarters of their own, Mr. L. was unprepared for the responsibility involved. The symptoms of her illness became acute and rest at the Convalescent Home was recommended. The referring psychiatrist had not prescribed occupational therapy. The occupational therapist and the caseworker discussed a plan to encourage Mrs. L. to choose some work in the shop and to bring it to a successful conclusion with the therapist's help. It was hoped this might encourage, reassure her and build self-confidence. On the doctor's next visit to the patient, the occupational therapist and caseworker met him in the shop and talked over with him their ideas. The doctor was interested, gave his approval and followed her progress in the shop. The doctor felt that the patient benefitted greatly from the regimen.

How a Resistive Patient was Helped to Accept Occupational Therapy

Mrs. R. was an out of town patient, active with a Detroit psychiatrist. So that he might have the opportunity to further study his patient, confirm his diagnosis and render prognosis, he recommended several weeks at the Convalescent Home. The caseworker was to initiate regu-

lar contacts with the patient, obtain social history, and arrange for psychometric and Rohrschach tests. In the first contact, while discussing the facilities and activities in the Home, the caseworker suggested the patient might like doing something in occupational therapy. Her reaction was one of hostile resistance. In her role as a clergyman's wife, she had organized club activity and craft groups. Her ambivalence about her relationship with her husband and what was involved in being a clergyman's wife colored her reaction to the caseworker's proposal. She was reassured that she was completely free to make her own decision. However, she was introduced to the therapist and shown through the department. The caseworker and occupational therapist discussed the matter. It was thought important for the latter to express interest in the patient, to be friendly, but to make no effort to get her to work. In a day or two the patient herself asked to do something. During the rest of her stay she developed a lively interest, did some original work which gave her considerable pleasure. When she arrived she had been depressed, hostile and morose. The experience in the shop, mingling with other patients helped her to socialize and contributed to her well-being and happiness during her stay.

How a Resistive Patient was Helped to Accept Social Service

A general practitioner referred Mrs. D. for a routine of rest and diet for underweight and nervous condition. The doctor was aware that there were social and emotional factors in the situation. He was willing that the caseworker make a contact during the patient's stay at the Home and report her impressions to him. However, he had not interpreted this to the patient. It was up to the caseworker to try to make a satisfactory contact without arousing suspicions or incurring resentment. Mrs. D. was friendly and pleasant with patients, but though courteous, was aloof with the staff. She was keenly interested in occupational therapy and spent a great deal of time in the shop. The therapist formed a very nice relationship with her and was able to interpret to her the caseworker's role and make an introduction. Because of her acceptance of the therapist, the patient could take on the new relationship. It was possible, under the guidance of the psychiatrist consultant for the caseworker to carry on some succesful psychotherapy.

CONCLUSION

The foregoing discussion makes obvious the fact that the occupational therapist and caseworker both dedicated to the service of patients, have a wide field for doing good individual and joint therapy in the setting of the McGregor Convalescent Home. However, certain factors which stem from the present philosophy of operation as well as the physical structure of the Home, have a bearing on the degree of success it is possible to attain and must therefore be taken into consideration. The following observations emerge from experience at the Convalescent Home:

1. Best results can be obtained when there is a consistent admission policy so that a definite group of patients is admitted. It is important for the referring physician and the caseworker and the occupational therapist to have contact before the patient's admission so that efforts are directed immediately into constructive channels.

2. The superintendent and the department of nursing must understand and be sympathetic to the objectives of the caseworker and the occupational therapist. There must be close cooperation among all the services so that the patient's schedule is planned with one end in view.

3. Physical facilities should include projects intended solely for men removed from patients's rooms so that the noise of saws and other equipment is not objectionable. There should be separate rooms for occupational therapy work and recreation.

4. The social service office should be easily accessible to both men and women, preferably near the occupational therapist's room.

5. The work schedules of the occupational therapist and caseworker should include frequent contact with community activity, committee work, visits to similar services, professional meetings etc, in order to provide stimulation for their work.

Although not always possible in large institutions, at the Convalescent Home it has been found that the informal environment and small patient load enables staff to become aware of patients as individuals. The occupational therapist and caseworker are free to apply their skills in the interests of the patient as they see the need. They are unhampered in experimentation in their respective fields by the need to adhere to any given routine. Out of a good relationship with each other, and a background of full professional training and experience which orients both to the mental hygiene field, the occupational therapist and caseworker have developed mutual understanding of each other's work and close cooperation from which the patient benefits.

Of course, the future goal is to stimulate among all staff members such understanding and cooperation, so that all services aavilable at the Convalescent Home can still further be utilized to serve the greatest possible number of patients admitted. Interpretation in staff case discussions, in exchange of literature and in informal contact has already proved its worth and will be continued and expanded.

NATIONALLY SPEAKING

From the President

CHANGE OF PUBLICATION OF JOURNAL

The Board of Management regrets to announce the resignation, at the end of 1949, of Miss Charlotte D. Bone as Editor of the American Journal of Occupational Therapy. Miss Bone's work in establishing and developing the new magazine on high professional standards constitutes an outstanding service to the Association and the profession.

Considerable credit is also due the resigning publisher, Mr. Shepley Cleaves, for the excellent styling and format of the Journal and for promotional work in advertising and circulation; and Miss Katherine Rand for her work as Assistant Editor.

With the first issue in 1949, former Vice-President Lucie S. Murphy assumes the duties of Editor and also those of advertising and circulation manager. Mrs. Murphy was appointed by the Executive Committee following the resignation of Miss Bone in November, 1948. The best wishes of all are with her in taking over the Journal. She will need your whole hearted support. The new address for your A. J. O. T. is 1313 E. Elmdale Ct., Milwaukee 11, Wisconsin.

KELLOGG FOUNDATION GRANT

The Executive Committee is happy to announce the receipt of an additional grant of $10.000 for this year from the Kellogg Foundation. It is indicated that $8,000 may be available next year subject to approval of the progress report of the Education program. This generous contribution has made possible the continuation of the research program of the Education Office. We are indeed grateful to the Kellogg Foundation for this much needed support of the Education projects. However, our membership and schools must realize that it will be necessary for the Association to assume full financial responsibility for the Education Office as of September 1st, 1951.

SCHOLARSHIPS FOR STUDY IN POLIOMYELITIS

The Polio committee in conjunction with representatives from the National Foundation for Infantile Paralysis has selected the recipients of the twelve scholarships for the course to be given by the University of Southern California in the summer of 1949.

The Polio committee is also happy to announce the opportunity for advanced study in poliomyelitis is anticipated through the approval by the National Foundation for Infantile Paralysis to include graduate occupational therapists in the courses given at Warm Springs Foundation. Final details concerning these courses, the application of candidates and the regulations of these scholarship grants will be released as soon as possible by the Education Office in conjunction with the Special Committee on Poliomyelitis.

Congratulations are in order for the excellent results of this committee's fine work.

From the Executive Director

As we write this column for a deadline necessarily set more than six weeks before the earliest date you can read it, it seems appropriate to hope for all of you that the New Year is proving to be a good and happy one. Even though it's late, it's one way of acknowledging all your attractive and thoughtful Christmas cards. It was a pleasure to the entire staff to hear from so many of you.

The holidays were no doubt a time of greatly increased responsibilities for most of you, but they gave us here in the National Office a brief and welcome respite. It seemed that everyone was too busy with hospital decorations, programs, parties, shopping, etc. to write or visit the AOTA; so in the release of pressure from routine correspondence and duties we turned to the study of a few of the questions we are so often asked but seldom able to answer. We thought the results might be of interest to you.

One of these studies was to determine the distribution of all registered occupational therapists by disability area or field of specialization. For so long now, we have just casually said that probably more than half of us were in psychiatric work and the rest scattered throughout various other types of hospitals. With the sharp shift in emphasis, during the

War years particularly, on the field of physical disabilities, it seemed doubtful if this generalization were still true. The table below shows that it is not. It should be noted that all figures are approximate only, since it has not been possible in every case to check on types of hospitals where only a proper name has been given. There are also discrepancies in the fact that many Army, Navy, Public Health Service, Veterans Administration and other general hospitals have psychiatric, pediatric, tuberculosis and similar types of services; this would automatically reduce the number now listed as being in general hospitals and increase somewhat a few of the other designations. It is not likely, however, that it would significantly change the general proportions. An accounting of those with "positions unknown" would also probably be distributed on a normal curve through the named classifications.

Another of our investigations was made to find out how many different institutions and agencies have departments employing registered occupational therapists. This was much less accurately revealed by our records here. At the present time, all that can be said is that we know of 742 separate departments and we have questioned about an additional 567 agencies, in which there is reason to believe that there once were and may still be occupational therapists. From questionnaires soon to be sent out, it may be possible to verify many of the doubtfuls and, at a later date, to publish revised figures.

SURVEY OF REGISTERED OCCUPATIONAL THERAPISTS BY FIELD OF SPECIALIZATION

(as of December 20, 1948)

	Paid Up	In Arrears	Total	% of Total
Inactive	721	226	947	.28
Psychiatric	455	84	539	.16
General (includes Army & Navy)	417	48	465	.14
Vets. Adm. (includes psych., gen'l, etc.)	422	31	453	.13
Physical Disabilities	307	8	315	.09
Position Unknown		275	275	.08
Miscell. types of Occupational Therapy	137	10	147	.04
Schools 50				
Blind & Deaf 23				
Study 17				
Executive 14				
Private 13				
Other 30				
147				
Tuberculosis	110	4	114	.03
Other than Occupational Therapy	54	19	73	.02
Arts & Crafts 13				
Teaching 35				
P. T. 4				
Miscell. 21				
73				
Pediatrics	47	9	56	.02
TOTALS	2670	714	3384	.99

Total Active in Occupational Therapy	2089
Total Inactive in Occupational Therapy	1295
Total Registered Occupational Therapists	3384

From the Educational Field Secretary

The Education Office is deeply grateful to the Kellogg Foundation for its continued support. The new grant, announced by your President, makes possible the completion of some of the projects begun during the past few years. It will also enable us to undertake several other studies which are considered by the Board of Management of the Association to be essential to the advancement of the profession.

Our Education Office was established with the aid of the first Kellogg Foundation appropriation in 1944, and since then, has been supported by special grant from that organization. During the war years, the services of the Educational Field Secretary were devoted primarily to recruitment for training to meet the increased demands for personnel, and to the advisement of the many occupational therapy courses which were rapidly developing in colleges and universities throughout the country. The end of the war brought about the stabilization of this expansion program, but the need for unifying and standardizing our educational system, and for providing continued developmental assistance from a central point had become apparent.

With the approval of the American Occupational Therapy Association Board of Management, a program of educational research was begun in 1946. The new national registration examination is the most widely known feature of that program to date. Many other projects are under way however, and it is with the hope of bringing the various aspects of our program closer to you that this and future reports will be made from the Education Office.

In order to better understand the purpose of our education program, let us consider some reasons given by allied organizations for the establishment of such a service. The American Physical Therapy Association lists as important objectives of their education program the following:

> "... to study existing physical therapy educational programs; to provide discussion and encourage the development of these programs to meet the employment demands in the field; to prepare materials for and promote vocational guidance activities in high schools and colleges to interest prospective students in physical therapy; to prepare and distribute educational materials; to furnish counseling and guidance services for members interested in graduate educational opportunities; to encourage the maintenance of standards in education and employment."

The Education Office of the American Physical Therapy Association has been in existence since 1946 and is supported by a special grant.

The National League of Nursing Education enumerates these prime objectives of its program:

> "... to consider questions relating to nursing education; to advance educational aims and standards in nursing; to assist in furthering the development of public health; to aid in measures for public good by co-operating with other bodies, educational, philanthropic, and social, to promote helpful and cordial professional relationships, and to develop and maintain the highest ideals in the nursing profession."

The National League of Nursing Education, organized in 1893, is supported in part by dues of League members, sales of publications, and by income from services rendered.

Our Association's education program is not vastly different from these approaches or those of other professional organizations. Most of the aims listed above are among our interests and responsibilities too, but at present we are concentrating more on the research type of program than the better-known service type of activity. The reasons for this are two-fold; first, occupational therapy schools and the General Office of the American Occupational Therapy Association have in the past assumed many of these other responsibilities; and secondly, because of our rapid growth during the last decade, it has been considered vitally important to study problems concerned with our didactic and clinical education.

By consulting the September-October 1948 issue of AJOT, you will be able to trace the development of this research program to that date in the Report of Activities of the Education Office, 1947-1948 (pages 306-310). A brief progress report from then to the present follows.

1. RATER'S AND DIRECTOR'S GUIDES, INTERPRETATIONAL KEY AND CLINICAL TRAINING REPORT FORM: The questionnaire to be used for the analysis and evaluation of these materials is being developed. It will be sent to all clinical training directors early in 1949. The clinical training reports of all 1948 registration examinees will also be analysed statistically as an additional means of evaluating the effectiveness of the rating form.
2. ACTIVITY SURVEY: The compilation of the survey data is nearing completion. Interpretation of the data to schools of

occupational therapy and participants will follow and should be accomplished in the near future.

3. PERFORMANCE REPORT FORM: A sample of the final form has been submitted to the committee for criticism, suggestions, and approval. The recommendations of the committee will have to be incorporated, before the form can be printed and put into use.
4. REGISTRATION EXAMINATION: The evaluation and stabilization of the registration examination are progressing satisfactorily. An intensive drive for additional test items is now being made in order to obtain a large pool of alternative items for future use.
5. GRADUATE STUDY: The National Foundation for Infantile Paralysis scholarship candidates were selected by a special committee appointed by the Chairman of the Polio Committee in conjunction with the Educational Field Secretary and representatives of the National Foundation for Infantile Paralysis. We feel that a very worthwhile group of occupational therapists are the recipients of this honor and we wish to congratulate them on their good fortune.
   The material compiled by the Graduate Study Committee during the year 1947-1948 and filed in the Education Office has been of assistance to several occupational therapists. A considerable number of our co-workers apparently are engaged in research work or graduate study, and are interested in knowing what has been done by others in this field.
6. CLINICAL TRAINING POOL: Under the direction of a special committee appointed by the Chairman of the Subcommittee on Clinical Training, a Clinical Training Pool has been developed and established in the Education Office. The pool is to take care of unexpected vacancies which occur in assignment of students for training and in the clinical training schedules. It is not intended to take the place of regularly scheduled commitments.

   Information on vacancies in clinical training is coming in from all parts of the country. Since the schools will have completed most arrangements for clinical training for this next year, requests for additional clinical training opportunities for the immediate future will probably occur only occasionally.

The Education Office again expresses its appreciation to all those who are assisting in the development and application of these various studies. We are grateful to the members of the standing and special committees, as well as to the many others who are participating, for their generous contribution of time and work. The research program of the Education Office affects all members and the development of the profession as a whole. It needs the support of everyone and must of necessity be the result of the combined thinking and work of many.

EDITORIAL

A RESPONSIBILITY

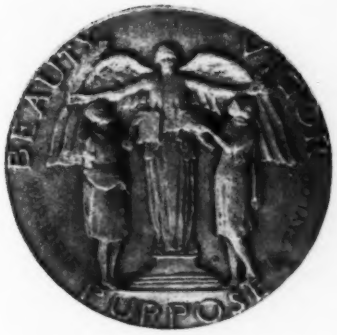
The American Journal of Occupational Therapy is the official publication of the American Occupational Therapy Association and therefore is your means of communication. The *Journal* will be what you want it to be but only if you make your requests known.

Miss Charlotte Bone has been editor for the last two years, and Mr. Shepley Cleaves has been publisher. The two did an excellent piece of pioneer work in establishing policy, format, and style. Your present editor will make every effort to continue the fine standards they established.

But the American Journal of Occupational Therapy can only grow with the American Occupational Therapy Association and meet the changing needs of the profession if every member accepts her responsibility and contributes to this growth and expresses ideas for improvements. The *Journal* can meet your needs only if you keep the editorial office informed of your wishes. All suggestions, ideas, notices, and articles will be greatly appreciated.

If a department is doing an interesting study the therapist or the physician in charge should be urged to write an account for publication in the magazine. If the news is interesting but not of a length or content suitable for a manuscript, write a letter to your editor. Such material can be incorporated in the *"Letters to the Editor"* Section.

Above all, remember the American Journal of Occupational Therapy is your magazine. Is it adequate? Is it professional? Is it what you want? It can be developed as the majority of you want it developed in direct ratio to the interest you evidence.



HONORS AWARD

Pictured in this section are the four members of the American Occupational Therapy Association that were chosen as outstanding *"Women of Achievement."* Annually the Women's National Institute award a bronze Medallion of Honor (pictured above) to outstanding women in specialized fields. Among last year's recipients of these awards were the Honorable Edith Nourse Rogers and Mary Roberts Rinehart. This year the Women's National Institute chose to honor occupational therapy at their 1948 Women's International Exposition held in New York City, November 1-7. It was the Silver Jubilee of this world-famous occasion and more than one hundred exhibits were featured on the ground floor of New York's 71st Regiment Armory which stretches nearly a full city block.

Occupational therapists were indeed fortunate to have their profession honored at such an outstanding ceremony and were well typified by the members chosen by our Board of Management from a list of highly qualified candidates proposed by the House of Delegates. Everyone will agree that the four following candidates chosen represented our group admirably.

Mrs. Winfred Kahmann, O.T.R., Director of Occupational Therapy at the University of Indiana Medical Center, Indianapolis, Indiana, is president of the American Occupational Therapy Association. She has long been active in the field and during the war was Chief of the Occupational Therapy Branch, office of the Surgeon General, U.S. Army.

Miss Marjorie Taylor, O.T.R., Director of the Milwaukee Curative Workshop, Milwaukee, Wisconsin, was previously also Director of the

Mrs. Winifred C. Kahmann

Occupational Therapy Department at Milwaukee-Downer College. The Curative Workshop, under Miss Taylor's direction has grown to be one of the best-known centers for functional therapy in the country.

Miss Marjorie Taylor

Miss Helen Williard, O.T.R., Director of the Philadelphia School of Occupational Therapy, Philadelphia, Pennsylvania, has always been a leader in the profession. At present she is successfully chairmaning the Education Committee, the largest standing committee of the American Occupational Therapy Association.

Miss Sue Hurt, O.T.R., Director of Occupational Therapy, Washington University, St. Louis, Missouri, is on temporary leave to get her Master's Degree from New York University. Miss Hurt is one of our foremost authorities on functional therapy, and the first occupational therapist to be appointed Major in the Army Reserve, Women's Medical Specialists Corps.

A bronze Medallion of Honor was also awarded to several "Ideal Career Girls", the objective of this project being "To encourage, advance and aid the business or professional lives and the private lives of young women between the ages of 20 and 30 by giving recognition to career girls in that age group who most nearly fit the 'ideal'...." The occupational therapist to be so honored was Miss Mildred V. Bond, 1st Lt., WMSC (OT). Everyone who has worked with Miss Bond finds that her enthusiasm for occupational therapy is contagious. She is able to inspire both her patients and the people with whom she works. She is long remembered by the patients whom she has treated.

Miss Sue Hurt

Miss Helen Willard

Lieutenant Bond, whose home is in Montgomery, West Virginia, graduated from Milwaukee-Downer College, Milwaukee, Wisconsin with a B. S. in occupational therapy in 1941. After two years as a staff occupational therapist at the Milwaukee-Curative Workshop, Lt. Bond was appointed to the civilian position of Chief Occupational Therapist, Ashford General Hos-

Miss Mildred Bond, 1st Lt.

pital, White Sulphur Springs, West Virginia, and later transferred to Percy Jones General Hospital, Battle Creek, Michigan. She served there until integrated in the Regular Army on June 7, 1948, and assigned on temporary duty to the Office of the Surgeon General, Department of the Army in the Occupational Therapist Section of the Women's Medical Specialist Corps.

Last September Lieutenant Bond reported to the University of Southern California, Los Angeles, to undertake study leading to a master's degree in occupational therapy. This training is part of the planned, rotating and progressive pattern of experience and education established by the Department of the Army in the Career Management Program for all Army officers.

An impressive program of preliminary ceremonies was planned for the evening of November 1 to celebrate the 25th anniversary of the Exposition. *"World Messages"* by Drew Pearson and an address by New Jersey's Governor Driscoll preceded the presentation of the Women of Achievement awards by Ted Malone on a nationwide broadcast. Misses Taylor, Willard and Hurt accepted in person, while Miss Eva Otto received Mrs. Kahmann's medallion in the latter's absence. Earlier on the same day, Lt. Col. Ruth A. Robinson, Chief of the Occupational Therapy Section of the Women's Medical Specialist Corps of the Army, accepted the Career Girl Award on behalf of Lt. Bond.

EVENTS CALENDAR

FEBRUARY 28 - MARCH 3

International Council for Exceptional Children, Hotel Fairmont, San Francisco, California

MARCH 19-20

Education Committees, American Occupational Therapy Association, Hotel Cleveland, Cleveland, Ohio

MARCH 21

Board of Management, American Occupational Therapy Association, Hotel Cleveland, Cleveland, Ohio

MAY 18-21

Association for Physical and Mental Rehabilation, Hotel New Yorker, New York City

MAY 23-27

American Psychiatric Association, Windsor Hotel, Montreal, Canada

MAY 30 - JUNE 3

International Congress on Rheumatic Diseases, New York City

JUNE 19-24

American Physical Therapy Association, Copley Plaza Hotel, Boston, Massachusetts

AUGUST 20-27

American Occupational Therapy Association, Hotel Book-Cadillac, Detroit, Michigan

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A commercial exhibit is assured for the 1949 convention, August 23-25. There will be thirty-two exhibits booths.

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SCHOOL SECTION

WAYNE UNIVERSITY
Detroit, Michigan

OCCUPATIONAL THERAPY CURRICULUM

BARBARA JEWETT, O.T.R.
Assistant Professor and Director

Wayne University, a municipal university, is the only institution of its kind under the control of a city board of education chosen by a direct vote of the people. It has an enrollment of approximately 18,000 students and ranks 17th in enrollment among the country's institutions of higher education. The university is located in the cultural center of Detroit which includes the public library, the art institute, the Rackham Memorial building and several muscums.

Wayne University is a unification of twelve colleges and schools, the oldest of these, the College of Medicine was organized in 1868. Established in the following order are: the Colleges of Education, Liberal Arts, Pharmacy and Engineering, the Schools of Law, Graduate, Public Affairs and Social Work, and General Studies, the College of Nursing, and the Schools of Occupational Health and Business Administration. All of these have been accredited by their several fields and offer cultural and professional training of high quality.

The University Division of Student Personnel deals with many non-instructional services to the student including: Freshman Days Program; the orientation of freshmen; counseling on housing problems; general educational counseling; vocational guidance; testing; student financial aid; placement; student activities; student religious activities; foreign student counseling; alumni affairs; student health service and mental hygiene.

The Wayne University of Occupational Therapy Curriculum was started in 1944 as a result of careful thought and action of a faculty committee guided by Dr. John J. Lee, dean of the Graduate School (newly elected president of the National Society for Crippled Children and Adults). In February 1946 a registered therapist joined the Wayne University faculty to supervise and teach the professional work and to revise the curriculum to meet the standards set up for approved schools.

Wayne University offers a Bachelor of Science degree in Occupational Therapy which may be received from the College of Liberal Arts or the College of Education. In the College of Education one may receive in addition to the degree a Provisional Teacher's Certificate.

The admission to the curriculum in the freshman year is consistent with the university practice of accepting all who meet scholastic qualifications for admission. The screening of candidates for the professional work is done by a counseling system by the director of the curriculum, assisted by a selection committee during the freshman and sophomore years.

Although the curriculum utilizes the facilities of the colleges of Liberal Arts, Education and Medicine, the professional training is centered in the Grace Hospital. A cooperative Occupational Therapy Department was set up. Fully equipped it provides office space, class room facilities and an actual "work shop" which was set up as a laboratory where students under professional guidance direct the treatment programs for both hospital and "out patients." Outstanding technical and trade schools, and the Pewabic Pottery offer facilities for craft courses.

In addition to the four years of academic work the degree requirements include ten months of experience in clinical affiliations. These training centers are primarily in the Detroit area and almost entirely in the state of Michigan which makes for a closer relationship between the clinical director and the curriculum director. It also gives Wayne University an opportunity to contribute to the service in the community.

A post degree curriculum, designed for students who enter with a college degree, requires a minimum of two semesters in residence plus the ten months of clinical training.

In keeping with the general attitude of Wayne University and its desire to meet its responsibilities to the community through education and service, it offers a training for Volunteer Occupational Therapy Aides. The course has been conducted through the cooperation of the Detroit Occupational Therapy Association and was designed for the older high school girls as a service program for those who were members of Senior Scouts, Horizon Clubs or Y-Teens. This program has been most enthusiastically enjoyed by the girls and also the occupational therapists in Detroit who find this volunteer service most useful and stimulating.

Wayne University's Occupational Therapy Curriculum is young with only eleven graduates to its credit. The growth has been gradual and now there are fifty students enrolled in the curriculum, including six men. Wayne University is eager to produce quality and like other good schools is constantly striving to revise and improve the instruction and experiences it can give to its students.

FEATURED O.T. DEPARTMENTS

A DESCRIPTION OF THE OCCUPATIONAL THERAPY PROGRAM AT INGHAM SANATORIUM

BETH MORRISON, O.T.R.,
Director of Occupational Therapy

Occupational therapy at Ingham Sanatorium is considered one vital component of a well-integrated total rehabilitation program. By *"total rehabilitation"* is meant everything of an extra-medical nature which is done for the patient. Rehabilitation has four distinct phases, Social Service, Vocational Counselling and Guidance, Occupational Therapy, Educational and Recreational Therapy; in order to function properly all must work in close and smooth harmony. Of these three professional workers, one is selected to act as director of the department and perform the administrative duties. The philosophy of the entire staff is to assist the patient in adjusting to hospitalization, to help him vocationally, thus preventing reactivation of the disease, and to aid the patient in maintaining his independence.

The rehabilitation department was started in 1942 as a demonstration program in conjunction with the Michigan Tuberculosis Association. This arrangement continued until 1945, when the Ingham County Tuberculosis and Health Society undertook the sponsorship. During this three year period, one worker had been employed and this person did both the social work and vocational counselling. The craft work was done on a volunteer basis.

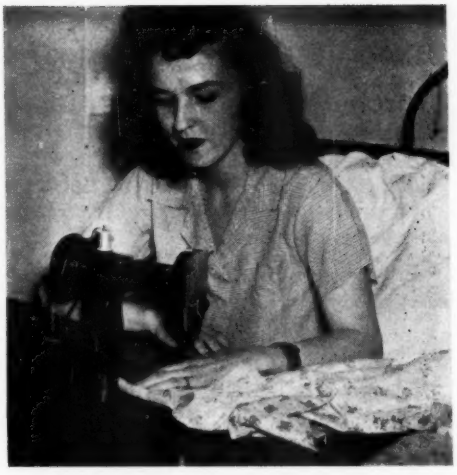
Class in fly tying

In 1946, the occupational therapy department was organized by the present director. The objectives of the program were designed to meet the needs of the patient population. One of the most important functions is to teach an avocation to patients in order that they use the long hours of convalescence at home constructively. Most break-downs occur in the first two years after discharge and by providing a suitable leisure time activity the patients are not as inclined to return to vigorous sports and past-times contraindicated.

Maintaining the family relationship is also an aim of the occupational therapy department. It is extremely important that the hospitalized member of the family feel that he is not dissociated. In the case of wives and mothers, home making arts and sewing are taught. The women are encouraged to sew and knit clothing, and even do the family mending. Husbands and fathers are encouraged to make articles and toys for the family, do minor radio repair, and it is hoped that soon a home mechanics course may be established to help these men make minor household repairs and thus learn a useful skill and save electrician and plumbing bills.

A homemaking course which is sponsored jointly by the Homemaking Division of the State Board of Control for Vocational Education and the Altrusa Club of Greater Lansing is offered for the women. A trained home economist spends two afternoons a week at the sanatorium and such topics as personal grooming, nutrition, care and selection of clothes, and interior decorating are offered. In connection with these lessons, interesting exhibits are arranged, style shows, table settings, flower arrangements, the new merchandise which is being displayed, and even fancy cake and cookie ideas.

Last year a bed-side sewing table was designed for the patients. This table is one of the first of its kind to be used. It is wide enough to slide over the bed and is raised and lowered by means of a hydraulic pump. An opening is cut in the top to accommodate a Singer portable sewing machine and when the machine is removed, a cover is added and the table may be used for a cutting or work space. The company which constructed this remarkable device is known as Rehabilitation Technicians and is located in Kalamazoo. The organization is unique in that it is a non-profit group which have as their goal the re-designing of machine parts and safety devices which enable a handicapped person to work more efficiently.



A young mother making clothes on the bedside sewing machine.

Occupational therapy also plays a part in the bedside teaching program. A part-time teacher is provided by the State Department of Special Education and her tutoring is available to patients who are nineteen years old or younger. Through an arrangement with the school, credit may be given in creative crafts, sewing, home making arts, and journalism (for work on the patient publication), all of which are supervised by the occupational therapy department.

In order to provide a more therapeutic program, part of the materials and equipment are furnished to the patient free. This item in the budget is supplemented by funds from the American Red Cross.

In April 1947, the Michigan Tuberculosis Association, and State Vocational Rehabilitation developed a plan which put into operation in the sanatorium as an experiment. The plan provided that funds for operation would come in part from Vocational Rehabilitation on a pre-vocational level. Thus with the increased budget more professional services and additional equipment would be offered the patient. In addition, the arrangement is desirable since

the vocational rehabilitation agent has an earlier contact with the patient and is better able to arrange for a rehabilitation plan with the hospital staff. Now fifteen Michigan Sanatoriums are operating under this plan and so far, the results are gratifying.

Determining skills and abilities is another aim of the department. The vocational counsellor administers tests, collects work and school histories, and discusses vocational choices with the patient. The therapist tries to plan activities which will demonstrate the patient's ability in some actual work project, determine work habits, aptitudes, and interests. A conference is then held with the rehabilitation staff, doctor, and vocational rehabilitation agent and a well-rounded plan is outlined for the patient.

Other services through the rehabilitation department include the mobile library (a county sub-station); a shopping service, provided by the College Women's Volunteer Organization, and the Gray Ladies; monthly movies and a weekly entertainment. Special classes are held when possible and such subjects are typing, photography, and fly tying are taught.

Since July 1947, the department has been accepting standards for clinical training. The emphasis in this affiliation is placed upon the total program and the coordination of the four phases of the department. This provides an opportunity for the student to comprehend the relationship and value of an integrated program.

Every patient in this 135 bed institution benefits from the rehabilitation program. The social worker interviews the patient and assists in emotional, financial, and legal problems. The vocational counsellor sees every patient and is informally acquainted regardless if the person needs a change of job or not. The occupational therapist visits all patients, even those not able to engage in any activity and thus good rapport is established. The whole program is directed toward helping the patient to help himself. The function of the department is to make hospitalization as pleasant as possible and to educate the patient to the limitations, liabilities, or possibilities of tuberculosis.

THE AMERICAN JOURNAL OF OCCUPATIONAL THERAPY

Published bi-monthly by the American Occupational Therapy Association. Editorial office 1313 E. Elmdale Ct., Milwaukee 11, Wisconsin.

Editor.....Lucie Spence Murphy, O.T.R.

Subscription rates: Price to members included in yearly fees; to non-members $5.00 a year domestic, $5.50 foreign.

Advertising rates: Rates for display advertising furnished on request. Classified advertising accepted only for Situations Wanted and Positions Available.

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Attend the 1949 Annual Convention at the Book-Cadillac Hotel, Detroit, Michigan, August 23-25.

SPECIAL NOTICES

1949 CONVENTION

Hotel Book-Cadillac, Detroit, Michigan
August 20-22 Pre-Convention Meetings
August 23-25 Convention
August 26-27 Institute

Of course you are planning to attend the 1949 convention of the American Occupational Therapy Association next August in Detroit, the automobile center of the world. Plan to come by boat, train, car, or plane, and your hosts, the Michigan Occupational Therapy Association, will make the necessary contacts to provide you with a shiny new model before you return home. What more could you ask?

In such an automotive setting you might expect something dynamic. And that is just what you will get—*a dynamic convention.* Already committees have begun to function under the general chairmanship of Barbara Jewett, OTR, Director of Occupational Therapy at Wayne University, Detroit. Working close to her in the planning is Adaline Truax, OTR, as program chairman. Adaline is a therapist in the Tuberculosis Division of Herman Kiefer Hospital, Detroit. A corps of workers scattered over the state are contributing ideas for the *"Motor City" convention.*

An interesting commercial exhibit is already an assured feature of the 1949 convention. Come and see for yourself the many new items the exhibitors have on display for you.

Yes, if you slipped up on making a New Year's Resolution, or if the ones you made already look worn and shabby, here is one that will be well worth clinging to: PLAN NOW TO BE IN DETROIT IN AUGUST FOR THE 1949 CONVENTION OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION . . . AUGUST 23-24-25.

P.T. AND O.T. SYMPOSIUM

The Section of Physical Medicine of the University of Wisconsin Medical School, the Wisconsin Chapter of the American Physiotherapy Association and the Wisconsin Occupational Therapy Association will sponsor the second annual Physical and Occupational Therapy Symposium at the University of Wisconsin Medical School on April 2 and 3, 1949. Advance registration for physicians, physical and occupational therapists will be necessary. There will be no registration fee. For programs write to Dr. Harry D. Bouman, Professor of Physical Medicine, University of Wisconsin Medical School, Madison 6, Wisconsin.

A. P. A.

The 105th annual meeting of the American Psychiatric Association will be held in Montreal, Canada, from May 23 to May 27, 1949. The Windsor Hotel will be headquarters, and arrangements have been made with the leading hotels in Montreal to house the necessary members and guests who plan to attend. For hotel reservations, write to Mr. Paul E. Joubert, Montreal Tourist and Convention Bureau, 1010 St. Catherine Street, W., Montreal 2, Canada.

There will be a Round Table on Occupational Therapy conducted by Dr. Walter E. Barton, Superintendent, Boston State Hospital, Boston, Massachusetts.

A. P. M. R.

The Association for Physical and Mental Rehabilitation will hold its Third Annual Convention at the Hotel New Yorker, New York City, May 18-21, 1949. More than 500 representatives from the nation's Veterans Administration, Army, Navy, and Civilian Rehabilitation Agencies will be present. For further information contact Mr. H. S. Wettstein, Corrective Therapy Section, VA Hospital, Bronx, New York.

SCHOLARSHIPS

Care of Poliomyelitis Patients

The National Foundation for Infantile Paralysis has just announced that scholarships will be available in 1949 to qualified graduate occupational therapists and physical therapists who need financial assistance to attend short term courses in the care of poliomyelitis patients. Details of this program are still being worked out, but in general, only citizens of the United States who plan to work in this country after completing the training will be eligible. A minimum of two years of clinical experience is required as a pre-requisite.

The requirements will be:

Occupational Therapists: Registration by the American Occupational Therapy Association.

Physical Therapists: Senior registration by the American Registry of Physical Therapy Technicians and/or membership in the American Physical Therapy Association.

Qualified candidates should write to the Professional Education Division of the National Foundation, 120 Broadway, New York 5, New York, for application blanks and detailed information.

Care of Cerebral Palsy Patients

The National Society for Crippled Children is offering scholarships for special study in cerebral palsy. These scholarships are available for the next three years to any registered occupational therapist. This is a change in the plans as announced in the October issue of the American Journal of Occupational Therapy.

Grants vary between $500 and $1000 and are offered for a minimum of three months training at an approved center offering specialized training in cerebral palsy. Another change from the original plans is that applicants are expected to make their own arrangements for acceptance at an approved center.

Applications for scholarships may be secured from the National Personnel Registry and Employment Exchange, National Society for Crippled Children and Adults, Inc., 11 South La Salle Street, Chicago 3, Illinois.

DELEGATES DIVISION

Josephine Davis, O.T.R., Editor

NORTHERN NEW ENGLAND

Delegate-Reporter, Doris F. Wilkins, O.T.R.

The Northern New England Occupational Therapy Association became an official branch of the American Occupational Therapy Association at the time of the Annual Convention in San Diego, California in November 1947 when the Board of Managers approved its application for affiliation. This made the regional group of Maine, New Hampshire and Vermont the 28th member of State and Regional Occupational Therapy Associations. Previous to this time, all of New England except Connecticut was included in the Massachusetts Association for Occupational Therapy. In recent years, however, a need was felt for a separate organization in which problems unique to this rugged region could be worked out. This was indicated by the increasing number of Occupational Therapy Departments in Northern New England along with the sudden spurt of interest in our profession in this area brought about by the new School of Occupational Therapy at the University of New Hampshire.

During 1948, we have met four times: March 12 at the University of New Hampshire in Durham, June 11 at the Vermont Sanatorium in Pittsford, Vermont, October 15, again at the University of New Hampshire. and December 10 at the Portsmouth Rehabilitation Center in Portsmouth, New Hampshire. Meetings are scheduled quarterly at one of the sixteen Occupational Therapy Departments within Northern New England. It is planned eventually to visit and become better acquainted with each one of the departments represented. To accomplish this aim takes interest and fortitude on the part of the members when distances and transportation are considered. Traveling, for instance, from Togus, Maine Veterans Administration Hospital to Brattleboro Retreat, a mental hospital in Brattleboro, Vermont, is a distance of 240 miles which would mean driving at least seven hours over circuitous, hilly roads across Maine and New Hampshire into Vermont. Trains do not cross these states from East to West.

Membership for 1948 was 33. The average attendance at meetings was 24 when counting both members and visitors.

The quarterly meetings consist of an all-day program beginning with a business meeting in the morning followed by a tour of the location. Luncheon together, reserved in advance by the hostess, is anticipated as a wonderful opportunity for relaxed, informal discussions. The feature of the day is the afternoon session when we hear guest speakers or see professional films.

At our first meeting in 1948, held in March at the University of New Hampshire, a letter from the House of Delegates was read announcing that the N.N.E.O.T.A. is now officially recognized as a Regional Association and entitled to membership in the House of Delegates. Luncheon at the famed Exeter Inn, Exeter, New Hampshire was a special event giving opportunity for members and guests from the University of New Hampshire faculty to get acquainted. The afternoon speaker was Mr. Wallace D. Black, Director of Vocational Rehabilitation in New Hampshire who gave us information about the expanding facilities for vocational rehabilitation of civilians made possible by Federal and State interests. Mr. Black also showed the exceedingly interesting color film, "Comeback," supplementing his talk.

The June meeting at Pittsford, Vermont gave an opportunity for members to see the rehabilitation program at the State Sanatorium and to hear an interesting and enlightening talk on "Newer Treatments in Tuberculosis" by the Superintendent, Dr. Louis Benson.

In October, we met again at the University

of New Hampshire. The Delegate's first report was followed by discussion of a number of items which had been referred back to the members. A new Secretary-Treasurer, Mrs. Sarah Smith Stowe, was elected to complete the unexpired term of Mrs. Mary Tillson Peretti who had resigned because of serious illness. Guests from the Boston School of Occupational Therapy and from Johannesburg, South Africa, stimulated our luncheon discussions. The speaker of the day was Dr. Mary M. Atcheson, Deputy State Health Officer who gave us a survey of the accomplishments and problems of the New Hampshire Department of Health.

At the December meeting held at the Portsmouth, New Hampshire Rehabilitation Center, Mr. Charles Kinnard, R.P.T., spoke on "The Correlation of Physical and Occupational Therapy." Mr. Kinnard is the newly appointed coordinator of Professional Services in the New Hampshire Society for Crippled Children and Handicapped Persons who was previously with the Institute for the Crippled and Disabled in New York. The subject brought forth a discussion of the possibility of meeting jointly with the physical therapists of Northern New England in order to promote the desired teamwork in our closely allied fields.

Although we are a new group and small in numbers, we have begun to make ourselves known in this area by accepting speaking invitations at churches, schools and clubs, by exhibits sent to associated professional groups and by publicity literature sent to high schools and private schools.

Our most tangible form of publicity came about through our desire to be represented pictorially at the national convention. Representatives from each of the Northern New England states met and decided to submit for exhibit at the convention a publicity album and large pictorial map of this region depicting locations of each occupational therapy department and activities in each. The enthusiastic response from all members was a tribute to the interest, loyalty and cooperation within the group. Within a matter of weeks, pictures had been taken in all occupational therapy departments, submitted to the Chairman for selection, enlarged to uniform size and an attractive album was complete. The beautifully done pictorial map is entirely credited to Miss Sarah Thorndike, O.T.R., talented therapist from the New Hampshire State Hospital. If the record numbers who attended the National Convention saw our map and album, we feel that Northern New England has had an auspicious introduction to the A.O.T.A. in spite of the fact that the album got placed in the Foreign Countries Area!

As a new Regional Association, we are looking forward to becoming even better acquainted with all members when you meet with us at the 1951 Annual Convention scheduled to be held in this area and we can personally show you our beautiful Northeast as well as our professional progress.

OFFICERS:

President: Eileen Dixey, O.T.R., Director of Occupational Therapy, State Hospital, Concord, New Hampshire.
Vice-President: Ruth Buffington Turner, O.T.R., Director of Occupational Therapy, Vermont Sanatorium, Pittsford, Vermont.
Secretary-Treasurer: (Mrs.) Sarah Smith Stowe, O.T.R., Assistant Director of Occupational Therapy, State Hospital, Concord, New Hampshire.
Delegate: Doris F. Wilkins, O.T.R., Supervisor of Occupational Therapy Curriculum, University of New Hampshire, Durham, New Hampshire.
Alternate: Eileen Dixey, O.T.R., Director of Occupational Therapy, State Hospital, Concord, New Hampshire.

KANSAS

Delegate-Reporter, Myrl Anderson, O.T.R.

The fall meeting of the Kansas Occupational Therapy Association was called by Miss Greenman at the time of the Refresher Course in Physical Medicine which was given at the Kansas University Medical School. This enabled the occupational therapists to have a joint meeting with the Kansas Physical Therapy Association and allowed our members to attend some of the lectures of the Refresher course.

Thirteen occupational therapists met at 5:15, November 2, 1948 in the Occupational therapy department of the Kansas University Hospitals at Kansas City, Kansas. Miss Nancy Greenman, president, was chairman. Miss West, Executive Director of the American Occupational Therapy Association talked to the group informally. She explained the organizational structure of our national organization and gave the group a feeling of responsibility toward it. She stressed the importance of feeling that we all are a part of the National Association and that its growth needs the help and interest from those in the field. Eleven occupational therapists attended the joint OT and PT dinner at the Hotel Ambassador. Dr. Donald L. Rose, Assistant Professor of Physical Medicine of Kansas University was toast master. The speakers of the evening were Miss Signe Brunnstrom R.P.T., Research Associate, New York University College of Engineering and Miss Wilma West, O.T.R., Executive Director, American OT Association.

Letters to the Editor

Challenge to a Therapist

By MARY E. BLACK, O.T.R.
Director, Handcrafts Division, Department of Trade and Industry, Province of Nova Scotia

The peninsula of Nova Scotia juts into the Atlantic Ocean from the Continent of North America like a gigantic pier inviting the sea commerce of the world.

With the exception of the narrow strip, the Isthmus of Chignecto, which connects it to the rest of Canada, it is virtually an island.

Over three hundred lighthouses protect shipping from the five thousand miles of rugged coast against which the restless Atlantic waves play a never ceasing symphony.

The distance from Yarmouth light to Cape North, as the crow flies, is approximately 374 miles and the Province varies in width from 60 to 100 miles. At no time is one ever completely away from the salty small of the sea. During the drive from one end of the Province to the other one passes through an unbelievable variety of terrain and scenery.

John Sebastian Cabot visited Nova Scotia in 1497 and claimed it in the name of England. The first settlers came in 1605 thereby establishing the earliest settlement on the North American Continent, north of the Gulf of Mexico. In 1625 King James of England accepted Nova Scotia as "The Royal Province" and granted a Royal Coat of Arms from which was later derived the Nova Scotia Flag. Today, Nova Scotia is the only Province of the Dominion having its own flag. So, it is easy to understand why loyal Nova Scotians display it in preference to the others they are entitled to use.

Racially, Nova Scotia is predominately English and Scottish; French and Irish equal each other in numbers as do a lesser number of Dutch and German. A few Poles, Italians, Danes and others have found their way to the Province to work in the mines or till the fertile farms.

For years the French and English fought for the early possession of the Province but after numerous wars, in which the English were finally victorious, they now live at peace with one another.

Following the Expulsion of the Acadians in 1775, settlers from various parts of the Old Country moved in and developed their own settlements; the Dutch and Germans along the South Shore, the Scots among the hills of eastern Nova Scotia and Cape Breton Island, hills which have never ceased to remind them of their native Scotland. Ten years later returning French Acadians were granted land along the Clare and Pubnico Shores which would belong to them in perpetuity. It is not at all uncommon, in driving through the Province, to pass from a section where one hears only Acadian French spoken into a nearby district where the people have "The Gaelic." There is too, the soft liquid speech of the MicMac Indians who now live almost entirely on the Reservations, wards of the Canadian Government.

It has been said that Nova Scotians are a people unto themselves. Austin F. Cross, writing about Nova Scotians in "Canadian Business" in March, 1947, offers this description: "Take a Yankee, add chunks of straight Englishman, put in a tincture of Sassenach, garnish with Eighteenth Century German, a touch of Dutch, supply a pinch of pure Acadian, sprinkle well all over with Highland Scot, strain through a Canadian sieve—and you have a Bluenose." He adds further, "Nova Scotia is a place of people rather than of products, who they are and who they were counts for more in Nova Scotia than in any other Province."

Nova Scotians have toiled hard and long for generations to wrest and hold their land from the sea and from exploitation by outside big business. Within a generation they have twice sent their sons and daughters to war realizing the necessity because of their close proximity to Europe. Twice their harbours have become that "Eastern Canadian Port" from which the thin sustaining European life line was maintained. They have come to realize that their strength lies rather in emergencies than in normal living. Steadfast to old ideals, slow to undertake new ventures, they appear at times to lack confidence in their ability but a glance at the roster of famous Canadian and American statesmen, bankers, lawyers, doctors, financiers, disproves this theory. Initiative and ability unfortunately

have been directed toward the building up of other Provinces and Nations rather than toward the development of their own Nova Scotia.

Unfortunately too, the attitude of most Nova Scotians is one of defeatism. Only a psychiatrist with a full knowledge of all the contributing factors at his finger tips could attempt to analyze this attitude and then he would be baffled when asked to suggest treatment. It is a state of mind that has persisted for several generations and it is not an easy one to change.

It was against this background in 1943 that an occupational therapist, with twenty years of psychiatrist experience behind her, accepted the challenge of developing a Provincial handcraft program—a program that would give the people of Nova Scotia an opportunity to develop latent talents thus adding to income and enrichment of their cultural life.

The whole program, a complete right about face from considering the patient's reaction to considering the sales value of the product, was completely revolutionary. Medical concepts had to be discarded and thought given to commercial processes rather than therapeutic. However, it was soon impressed upon the mind of the therapist that this new program embraced therapy, applied not only to individual's contacted but to groups as well. Here was a distinct group problem to be dealt with—a problem of inadequacy and defeatism. Viewed from this angle the whole program took on added interest and a definite challenge. A program that seemed comparatively simple at first glance, in its concept of commercialism and culture, began to take on a deeper meaning as the large group broke up into smaller groups and small groups into people who became individuals—individuals with problems as acute as those suffered by many hospitalized persons.

It has been said that once a therapist, always a therapist and certainly occupational therapy training, with the consequent therapeutic outlook, is a definite asset in evaluating the people with whom one comes in contact.

During her training and forever after it is drilled into the consciousness of the therapist that she must work only on prescription from the doctor. It is with trepidation then that the therapist takes it upon herself to initiate a handcraft program for an individual, found within the group at large, whose health deviates from the normal.

Her only exculpation for this seemingly serious deviation is that few of these individuals are under medical care and in many localities doctors are seldom heard of even for a "borning." Although, in some districts today Government subsidized doctors fly in for emergencies during the winter, landing their planes on the frozen lakes or bays. At times conferences are possible with the county nurse if she happens to know the person under discussion.

Common sense must be the guide. A young woman, obviously a victim of tuberculosis, must tactfully be discouraged from accepting an order for a bolt of homespun woven on a 45″ loom, and, equally important, she must be offered a substitute because both economically and psychologically she needs the order.

A fisherman, so badly crippled with arthritis that continuation of his former occupation is out of the question, must be given a substitute not so much to bring in badly needed income but as a morale builder. All his life he has made and mended nets so there is worked out for him a netted shopping bag that has good sales value and the process of which is well within his capabilities.

The mother of a spastic child must be told as kindly as possible that the articles the child produces do not possess sales value but the child must, for his own good, be encouraged to continue. An analysis of the mother's ability brings forth the fact that she knows how to knit a very fine type of bush mitten. These, in gay colours, are in demand by skiiers who dislike loose snow sifting up their arms.

The isolation and hard work of a farm suddenly thrust upon the woman of refinement, through no desire of her own, is bound to have serious repercussions on her mental, as well as physical, health. Infrequent visits, but regular letters and the finding of markets for her particularly fine handwoven tweed helped one woman not only to overcome a severe depression but gave her courage and a desire to continue experimenting with the native dyes whose soft colours fascinate her.

A self-centered, definitely psycho-neurotic individual has, through the building up of a home industry that reaches into and enriches the lives of her neighbours, become a most successful business woman. The latent talents that laid undeveloped for years have been given an outlet that has completely changed her whole personality.

A young woman, denied a place in the

business world because of a chronic type of phlebitis, was at loose ends until she became interested in pottery. Because of her physical limitations she lives very much to herself but it is this living alone with time to think constructively that has afforded her an opportunity to develop a distinctive line of pottery. Shapes are imaginative but clean cut, decorative designs in keeping with Provincial flora and fauna and a glaze which she calls Nova Scotia spruces prove most interesting. Markets, which were her problem, were found for her and now her orders have become so extensive she has difficulty in filling them.

Wartime living and moving about with its attendant loss of stabilizing contacts with family and friends was fast leading a society woman into chronic alcoholism. Quite accidentally an interest in weaving was aroused. Although she is still interested only in the more simple techniques and needs frequent warnings to maintain high standards of workmanship, her production is quite extensive and she has received, with help, satisfactory outlets. Possessing a definite flare for clothes she has woven material for many attractive outfits for herself and her teen-age daughter. She is quite frank in stating that the weaving has proven a satisfactory substitute for the ever present cocktail.

Occupations open to the physically handicapped are limited at best with the result that graduates from the school for the deaf more often than not become dependent on the family. Therefore, when a home industry in weaving grew to the status where it became necessary to reach out into a neighboring village or additional weavers, deaf sisters, who had had some training in weaving at the school, were the first to apply. These two girls have made a splendid success of their work and are able, in a sheltered environment, to earn a livelihood in excess of that earned by their non-handicapped brothers and sisters. They are alert, well dressed and the elder is saving toward an advanced weaving course.

A Danish girl with her German husband settled in the Province shortly before the last war. Life did not move too smoothly for them and ended in a divorce with his deportation to Germany. Then came the war. Burdened with a German name and nationality, that did not rightfully belong to her, and with an inadequate knowledge of the language, this girl had a very difficult time during the years of conflict. Willing to work at anything she could find, she filled her lonely hours with knitting and other crafts at which she was most accomplished. In 1945 her work was brought to the attention of the Handcrafts Division. An interview followed and after an orientation course she was employed as a handcrafts instructor. With security at last she gained confidence, her language difficulties were overcome and she became a very valued staff member. Her services were abruptly terminated, however, by her untimely and tragic death. Her sister, equally talented but suffering with a chronic heart ailment, was given ideas from which she has created a range of shopping bags. Gay designs are embroidered with coarse wool on a handwoven homespun wool material made by a neighbour. These bags are sold through the gift shops and a profitable industry is being built up in a home where every cent must be considered.

War casualties in Nova Scotia were heavy and adjustment to a new life has been difficult for many women so it was gratifying when one of these mothers, on the verge of a breakdown, found peace through the collecting, grinding and polishing of the native agates found on the beach near her home. The collecting of the stones provides a definite outdoor activity which her garden had ceased to supply. The physical activity, heavy enough to induce sleep, is however well within her capabilities. The slabbing and polishing requires close concentration and the beauty of the finished stone fulfills her longing for the finer things of life. The sale of the finished stones, which she has learned to mount in silver, adds to an otherwise limited income.

A knowledge of psychiatry helps in recognizing the individual with paranoid tendencies who can so easily wreck a program; helps one to recognize the timid person who may and frequently does, have latent abilities; it is invaluable in supervising the work of instructors and in general aids in viewing the whole picture objectively rather than subjectively.

You may ask, "What is the relationship between all these individuals and the group as presented at the beginning of this article?" Early in the administration of the handcrafts program it was recognized that this Province-wide state of mind of defeatism could not be cured over night by any one carthartic administered to the group at large. It could not be attacked as a group project but rather through

individuals comprising the group, winning first the confidence of one person, then another and another until they, in turn, were interesting others.

Progress has been made and although it has not been spectacular, fundamentally it has been born of a desire on the part of the people for creative expression. To force the group to listen to lectures would have been useless.

Results, both cultural and economic, have been demonstrated in many ways but principally through the interest shown in the annual "Craftsmen-at-Work" Exhibition at which talented craftsmen are brought in from all parts of the Province to demonstrate various crafts. These men and women, from both urban and rural centers, freely discuss their various crafts without restraint because crafts speak a universal language and are not bound by race, creed, colour or social barriers. The sophisticated city craftsman sits enthralled listening to his fellow craftsman from the far reaches telling of his experiences in obtaining his craft media from the sea, his woodland or the clay pit along the river. His product usually has a freshness and primitive interpretation that is an expression of his closeness to nature and his inherent desire to create.

The handcraft program of Nova Scotia functions under the Department of Trade and Industry whose aims are far removed from Occupational Therapy concepts.

Yet, if one can add to these concepts of increased income, improved standards of physical living and cultural development, the therapeutic concept of easement of individual problems perhaps the therapist has found a way of meeting the over-all challenge.

Book Reviews

Reviewed by ARVILLA D. MERRILL, O.T.R., Chief Occupational Therapist
St. Elizabeth's Hospital, Washington, D.C.

"Crime And The Mind," An Outline of Psychiatric Criminology
by WALTER BROMBERG, M.D., formerly Director, Psychiatric Clinic,
Court of General Sessions, New York, N. Y.,
Senior Psychiatrist, Bellevue Psychiatric Hospital, N. Y.
J. B. Lippincott Company, Phila., Publishers, 1948, 219 pp. + viii, $4.50

"CRIME AND THE MIND"

The book is divided into two parts: three chapters in Part One and four chapters in Part Two, plus an excellent Bibliography and Index.

PART ONE—*The Legal and Social Environment of the Criminal*
It deals with prejudices and unconscious impulses common to each member of society as they actively influence attitudes toward the criminal.

CHAPTER ONE—*The Approach to the Criminal*
Psychiatric Criminology's attempt to expose and successfully manage the emotional overtones which arise toward criminals from our psychological heritage and culture.

CHAPTER TWO—*The Criminal and His History*
The author points out the great number of anti-social impulses in law-abiding members of society which could result in criminal acts if allowed expression. An historical background of the former attitudes toward criminals and the scientific treatments with special references to the pioneers in the field of Psychiatric Criminology give an added interest to this book. That intense emotional shock at the anticipation of punishment or effect of imprisonment may hinge on sudden bizarre changes in behavior is discussed thoughtfully.

CHAPTER THREE—*Psychiatry in the Law Courts*
The question of the legal concept known as the "Knowledge of right and wrong" is shown with its advantages and disadvantages to both society and the criminal. Psychopathic behavior is a major social problem today and demands all the research and thinking that it receives. Juvenile delinquency with the introduction of the psychiatric viewpoint into the juvenile courts with a new attitude toward detention and criminal court procedure is being adopted. Cases are handled whose disturbing behavior problems in the community are regarded as a symptom of emotional and social disease and not as a criminal offense. The closely knit team of Psychiatrist, Social Worker and Probation Officer effects a much greater improvement than formerly was possible. Dr. Bromberg points out the difficulties in patients' adjustment to prison life and the modern methods used to assist the patients in this adjustment and to future rehabilitation.

PART TWO—*The Individual Criminal*
This section deals with "the personality distortions of various types of criminal offenders in the commission of major criminal offenders."

CHAPTER FOUR—*The Psychopathic Personality*
A list of the various Psychopathic Personalities under consideration will present the interesting subject matter: The Paranoid Psychopath; The Schizoid Psychopath; The Aggressive Psychopath; Alcohol, Drugs and the Aggressive Psychopath; The Psychopathic Swindler; Sexual Psychopathy; Types of Sexual Crime; Aggressive Sexual Crime; Pedophiliac Crimes; Incest; Homosexual Offenses; Bigamy. Emotional Reactions of the Psychopath and Dynamic Aspects of the Psychopath. Many actual cases are cited as illustration of content. This book contains so much material with CHAPTER FIVE devoted to *"Emotional Immaturity and Crime,"* CHAPTER SIX, *"The Neurotic Offender,"* and CHAPTER SEVEN, *"The Cure for Crime,"* that it is impossible to give you much more than a brief outline of its contents.

There is an eleven-page Bibliography divided into SECTION ONE—*Historical and Legal;* SECTION TWO—*Sociologic and Criminologic;* and SECTION THREE—*Psychological and Psychiatric,* in which are listed references significant only in the development of concepts in criminology.

As the field of Occupational Therapy with criminals has been limited in the past, this well-written authoritative book should be used by every well-informed Occupational Therapist.

Handicrafts and Hobbies for Pleasure and Profit, MARGUERITE ICKIS. The Greystone Press, 1948, 310 pages, $2.98.

Reviewed by MARJORIE VETTING, O.T.R.

Anyone, old or young, an experienced hobbyist or beginner interested in a creative outlook for pleasure or profit will find this book of great value and interest. It contains explicit directions and instructions for making many worthwhile projects as well as stimulating hobbies such as stamp collecting, indoor gardening and photography.

To me, Marguerite Ickis' book is unique in that it includes many crafts and hobbies under one cover. Namely: plastics, whittling, model boats, model cars, model planes, model railroading, stamp collecting, soap sculpture, bookbinding, paper decorating and portfolio making, finger painting, paper pulp modeling and crayon craft, square knotting, netting, dolls, doll houses and furniture, textile decorating, block printing, leather, metal craft, drawing, lettering, indoor gardening, photography, felt craft, pottery, card tricks and magic, basketry, fishing flies and rods, woodworking, and weaving on small looms.

There are many helpful suggestions in Handicrafts and Hobbies for Pleasure and Profits as: the enlargement and reducing of patterns and designs, how to lay out patterns on various mediums, minimum equipment and supplies necessary for home workshops with adaptations for doing projects on a larger scale for profit.

Miss Ickis presents many diagrams, patterns and photographs to explain her instructions and enable the hobbyist to visualize his finished product.

This book should be of interest to housewives who would like to grow their own herbs. It would be invaluable to those interested in craft programs for boy or girl scouting. The Occupational Therapist would find it a wonderful craft reference book and useful in planning active and inactive projects and hobbies for their patients. Anyone looking for a hobby or recreation couldn't help but find something of interest to suit his tastes and be stimulated by this well written book.

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COMMITTEE REPORTS

THE HOUSE OF DELEGATES OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

Formation and Function

The House of Delegates of the American Occupational Therapy Association is composed of one delegate and one alternate from each of the affiliated state and regional associations.

Procedure for affiliation of state or regional associations:
An Association to be affiliated with the A.O.T.A. must meet the following requirements:

1. A minimum of ten active members shall be required. The Association must be composed wholly or in part of practicing occupational therapists. Other members of the Association should be placed in the same membership classifications as in the constitution of the A.O.T.A. Active members must also be active members of the A.O.T.A. (See A.O.T.A. Constitution). In some of the older associations non-registered O.T.'s hold active memberships. This is also true of the A.O.T.A. itself. All new members of associations, however, must meet the present membership standards. All associations requesting affiliation should conform with this policy. Associate or non-professional members may not vote.

2. An Association requesting affiliation should submit a written request to the Secretary of the House of Delegates. A copy of its constitution and a list of all members showing their membership classification should also be sent.

3. The constitution should provide for the election of a delegate and an alternate, who shall be registered occupational therapists and active members of the A.O.T.A. for more than one year before the date of their election. The term of the delegate shall be three years, and he may serve only two consecutive terms. The term of the alternate may be three years or less.

4. When the delegate of an affiliated association is delinquent in fulfilling her duties the Committee on Credentials will investigate the situation. After the delinquency has occurred for a period of one year, the local association will be informed that its delegate will no longer be recognized and that it will be necessary to elect a new delegate if the association wishes to continue its affiliation. If a new delegate is not elected, the matter will be brought to the attention of the House for action on ending of the affiliation. The association can then be readmitted only upon formal application to the Secretary of the House.

Function of the House of Delegates
The function of the House of Delegates is to make recommendations to the Board of Management of the A.O.T.A. regarding actions and procedures which it feels should be carried out. The House was formed in 1938 because it was felt that in this way it would be possible for local associations to present their problems and needs to the Board. Likewise through the Delegates the problems and needs of the A.O.T.A. could be carried back to local associations.

Only in regard to changes in the A.O.T.A. Constitution does the House act as other than a recommending body. All changes in the Constitution must be approved by the House of Delegates, as well as by the Board before presentation at the annual meeting to the membership for vote.

The House is, however, represented on the Board by six of its members. It is also represented on the Executive Committee by one of the six Board members.

Officers of the House of Delegates
Organization Officers
The officers of the House of Delegates are the Speaker, Vice-Speaker and Secretary. The Secretary also serves as Chairman of the Committee on Credentials. The term of these officers is one years, but they may be re-elected.

Board Members
Six members of the House are elected by the House to serve on the Board; their term being two years, three are elected each year to replace the three retiring. They cannot be elected from those who are in their third year because such persons cannot complete their term as Board members. It is preferable to have the Speaker of the House one of the Board members, but not essential, nor always possible.

If, for any reason, a Delegate Board member is unable to complete his term, the Speaker may appoint another Delegate to fill his place until the next meeting of the House.

One of the six Board members serves on the Executive Committee. This is usually the Speaker of the House, if it is geographically possible and if the Speaker is a member of the Board.

The officers and Board members are elected at the close of the annual meeting of the House, and serve through the next annual meeting.

Committees of the House, Appointment and Function
The Committee on Credentials is the only standing committee of the House. Its chairman is the Secretary, its members are chosen by the chairman. Its duties are: 1. To pass on the credentials of all delegates and alternates at the Annual meeting. 2. To consider requests for affiliation with the A.O.T.A. and recommend action to the Board. 3. To review the constitutions of affiliated associations and to submit to the House the names of those affiliated associations which do not comply within

one year with the recommendations made by the Committee on Credentials. Following action by the House, the association will be deprived of its vote and active participation in sessions of the House of Delegates until the recommendations are carried out.

The Nominating Committee of three or more members is appointed each year at the first meeting of the House from those delegates not eligible for office. It chooses a slate of officers and Board of Management members which is presented at the second meeting of the House of Delegates.

Other committees are appointed as indicated. The Chairman reports to the Speaker twice yearly on their accomplishments.

Duties of the Speaker of the House:

1. To preside at all meetings of the House.
2. To keep the delegates informed throughout the year regarding changes in policy or special actions by the Board of Management, and to keep the Board informed as to the feelings of the membership.
3. To prepare an agenda for the meeting of the House of Delegates to be sent to the delegates in the spring for suggestions and additions.
4. To send out the final agenda to the delegates before the annual meeting.
5. To summarize the minutes of the meeting of the House of Delegates for the record.
6. It is the duty of the Speaker of the House to request a stenotypist to record the minutes of the House of Delegates at the annual meeting.

Duties of the Vice-Speaker:

1. To preside at the meetings of the House of Delegates in the absence of the Speaker.
2. To serve as parliamentarian at all House of Delegates meetings.
3. If the Speaker should resign, to complete the Speaker's term.
4. To serve as editor of the Delegates Division in the American Journal of Occupational Therapy.

Duties of the Secretary:

1. To act as Chairman of the Committee on Credentials.
2. To take minutes of the meetings of the House of Delegates if a stenotypist is not available.
3. To send out credentials forms to the delegates. (Actually, this is done through the National Office, as is the clerical work on minutes and agendas).

Duties of the Delegate Board Member on the Executive Committee

The Delegate Board Member on the Executive Committee represents the House of Delegates and, regardless of his own opinion, should vote as directed on all subjects voted on or recommended by the House. On other matters, the Delegate Board members uses his own judgment.

After each Executive Committee meeting a report on actions taken and the reasons should be sent to the delegates. The minutes of the Executive Committee meeting may be sent as well, or a more extensive report. The latter is preferred by the delegates, as the minutes give only the action taken, not the discussion and reasons for the action.

The Executive Committee meets every two or four months. It is empowered to carry out the aims and instructions of the Board of Management. It implements their decisions and acts as a finance committee for the Treasurer. It cannot initiate action on its own part, but can make emergency decisions subject to the approval of the Board. It also acts in an advisory capacity to the Executive Director and Educational Field Secretary.

Duties of the Delegate Members of the Board of Management

The delegate members of the Board of Management represent the House of Delegates and must vote, regardless of their personal opinions, as instructed by the House on all recommendations made by the House. On all other matters they are free to use their own judgment.

As a general rule, the Speaker reports to the Board the recommendations of the House in his report. These are then acted upon.

New members should not hesitate to request clarification of points on which they are not clear. It will be found helpful by new members if they review the minutes of recent Board meetings.

The Board of Management functions as a policy making body. As it meets only twice a year, it is necessary for it to leave the carrying out of approved policies to either the personnel of the National Office, or to committees, such as, the Education Committee or Executive Committee.

Duties of the Delegate

The Delegate serves as the liaison officer between the members of the local association and the Board of the A. O. T. A. The importance of this position cannot be over-stressed. In voting in the House the Delegate represents every member of the local association and should be informed as to their opinions, problems, and needs. Likewise, it is the Delegates' responsibility to keep the members of the local associations informed as to national problems, needs, and changes in policy.

Delegates should be chosen for their ability to do this. Changes in delegates before the expiration of their terms should be avoided.

Special Duties of Delegates:

1. To present to their associations through the year all information passed on to them and to keep the Speaker informed regarding their reactions.
2. To serve as delegate reporter for A.J.O.T.
3. To help the A.O.T.A. Committees on special projects as requested.
4. To act as general information bureau for all requests from the National Office.
5. To answer letters when received.
6. To see that the National Office is informed correctly as to changes in office in local associations.
7. To pass on to the new delegate the minutes and other pertinent material.
8. The delegate of the area in which the annual meeting is held is to be responsible for making sure that adequate space is secured for meetings of the House of Delegates.

Meetings of the House of Delegates:

Meetings of the House are held yearly at the Annual Meeting; one prior to the first Board meeting and one before the second Board meeting.

Each affiliated association may be represented by a delegate and an alternate. If both attend, only the delegate may vote for the association, but the alternate may participate in the discussion. If the alternate for the Speaker and the Secretary are present, they may take the place of these officers in the voting.

If an association cannot send a representative, it may submit a written statement of the views of its members, which will be used as a guide to discussion, but does not constitute a vote.

Active members of the A.O.T.A. may be admitted as visitors to the meetings of the House of Delegates. Closed meetings may be held by a majority vote of the House.

Special meetings of the House may be called when necessary.

Harriet J. Tiebel, O.T.R.
Retiring Speaker, House of Delegates

OFFICIAL REPORT OF THE BOARD OF MANAGEMENT MEETINGS

HOTEL PENNSYLVANIA, NEW YORK, N. Y.

SEPTEMBER 6 AND 9, 1948

The Board of Management meeting was called to order at 9:15 A.M. by the President, Mrs. Kahmann.

Roll Call and Proxies

The following Officers, Board Members, Fellows and Delegates on the Board of Management were present:

Mrs. Winifred C. Kahmann
Mrs. Lucie S. Murphy
Miss Clare S. Spackman
Dr. William R. Dunton
Miss Naida Ackley
Dr. Walter E. Barton
Sister Jeanne-Marie Bonnet
Miss Lenore Brannon
Miss Mabel Davis
Miss Edna Faeser
Miss Dorothy Flint
Miss Margaret Gleave
Miss Sue P. Hurt
Miss Elizabeth Messick
Miss Bertha J. Piper
Mrs. Harriet J. Tiebel
Miss N. Meryl Van Vlack
Miss Beatrice D. Wade
Miss Carlotta Welles.
Miss Doris Wilkins

Proxies were held for:
Miss Myrl Anderson
Miss Jane E. Myers
Miss Catherine Worthingham

Minutes of the Previous Meeting. The minutes of the meeting of the Board at the Chase Hotel, St. Louis, Mo., on March 22, 1948 were accepted as distributed by mail.

Report of the Executive Director. Miss West reported that activities of the National Office had been largely concerned with routine matters pertaining to office functions. As of September, 1948, the AOTA lists 3219 registered occupational therapists, of whom 769 are in arrears, and 2982 members, 450 of whom are in arrears.

Since it was anticipated that the balance of the report of the Executive Director would be involved in various other reports and items on the agenda, Miss West suggested that further comment be withheld. It was so voted.

Report of the Treasurer. Miss Spackman distributed copies of a layman's breakdown of expenditures for the 1947-48 fiscal year and a tentative budget of income and expenses for 1948-49 for both the general and educational funds. She pointed out that income for the past year was $4,973 less than budgeted and $7,101 less than would have been received had all membership dues and registration fees been paid. In spite of this reduction in anticipated income, a balance of $2,873.53 was on hand as of the end of the fiscal year.

Miss Spackman discussed the need for making some adjustment to provide funds to tide the Association over the period from the end of the fiscal year in August to the beginning of the calendar year in January when dues and fees start coming in. In order to do this, it was suggested that bills for each calendar year be sent out in September of the previous year, made due and payable before the 31st of the following January. Second notices should be sent out on January 1 to all those who had not paid by that date. Failure to meet the established deadline of January 31 would mean loss of listing in the Occupational Therapy and no guarantee of back copies of the American Journal of Occupational Therapy. These measures would make it possible to publish the Directory earlier in the year and would also economize on publication expenses in not having to print copies in excess of those ordered.

Miss Spackman reported that the House of Delegates had discussed and approved this plan prior to the Board of Management meeting. A motion was made and seconded that it be put into effect as soon as possible. It was so voted. The Executive Director was instructed to incorporate various suggestions into a revised bill form.

The Executive Committee was empowered to borrow if necessary to meet expenses before the first of the year.

It was voted to economize on publication of the Directory by the following revisions: 1) to indicate membership in the AOTA by asterisks following the names of members; 2) to number state and regional associations in a key on the inside front cover and indicate membership affiliations by these numbers; 3) to letter schools of occupational in similar key and indicate professional education by such letters; and 4) to run all data together on continuous lines, indicating P. Ed., Exp., P.P. and P.A. by boldface type rather than by separate lines.

It was voted that the monthly financial statements to the Executive Committee be changed from auditor to lay form.

The budget for 1948-49 was approved subject to consideration by the Executive Committee with discretionary powers.

The report of the Treasurer was accepted subject to audit.

Report of the Speaker of the House of Delegates. Mrs. Tiebel reported the attendance of 27 delegates at the House meeting. Western Pennsylvania was the only state association not represented. No new state or regional associations applied for admission to the House.

Four recommendations were made by the house of Delegates to the Board as follows:

1. That the new type billing as voted in the Treasurer's report be approved.
2. That the American Occupational Therapy Association publish in the American Journal of Occupational Therapy a report of the nature and extent of its representation with other organizations and that it seek specific ways of furthering same.
3. That annual conventions alternate between formal and informal meetings, with the American Plan type hotel preferred. October is preferred over August; March is also proposed.
4. That the House of Delegates meet twice yearly, in conjunction with the Board of Management and Education Committee meetings, and that the agenda for each Board of Management meeting be sent to delegate Board members in advance so they may be instructed with regard to voting.

Action taken on the foregoing recommendations was as follows:

1. Voted (see Treasurer's report).
2. The Executive Director was instructed to prepare this report and to include in it contacts made by standing and special committees and state and regional associations. The report will subsequently be made to the state associations and possibly thereafter considered for publication in the American Journal of Occupational Therapy.
3. Voted
4. The question of bi-annual meetings was referred back to state associations for further discussion.
   It was voted that the Board of Management agenda be sent out in advance so that delegates might be instructed.

Referring to the question of moving the National Office to Chicago, it was reported that the House of Delegates expressed disapproval of the plan to move into joint offices with the American Physical Therapy Association. The March Board of Management action of approving this unofficial proposal

was clarified to the House of Delegates by stating that the Board of Management had not meant for the two organizations to share the same office; rather that they occupy separate offices in close proximity. The recommendation of the House of Delegates that the American Occupational Therapy Association investigate possibility of obtaining office space in Chicago with the American College of Surgeons or the American Medical Association was tabled in view of the indefinite moving date.

The House of Delegates also recommended improvement and expansion of the National Office placement service. The Board of Management replied that this would be done in so far as was possible in consideration of all other demands on office personnel's time.

Another recommendation was that if the Executive Director should be unable to attend meetings in which American Occupational Therapy Association participation is invited, that she appoint a local representative. The Board of Management approved this policy. It also voted to instruct the Constitution Committee, on the recommendation of the House of Delegates, to revise the constitution's present definition of an *"active"* member of the Association to include those registered occupational therapists who have never held a position.

The report of the Speaker was accepted with appreciation.

Report of the Educational Field Secretary. Since this report was made to the Education Committee, the House of Delegates and the General Session, and all Board of Management members had heard it at one or another of these meetings, it was voted to omit the report from the Board of Management agenda. (It has since been published in full in the September-October, 1948, issue of the American Journal of Occupational Therapy.

Report of the Education Committee. Miss Willard reported that during the past year the following schools have been given tentative approval pending inspection visits by officials of the American Medical Association: Iowa, Minnesota and Wayne Universities. The only new school which is not yet ready for final approval is Colorado College of Agriculture and Mechanic Arts. Inquiries have been received regarding the possibility of opening other schools in the University of California at Los Angeles, in Alverno College in Milwaukee and in Puerto Rico.

The Sub-Committee on Schools and Curriculum has been conducting two special projects: 1) survey of demand and opportunity for graduate study (published in September-October, 1948, American Journal of Occupational Therapy) and 2) development of a Curriculum Guide. Other problems being discussed and studied are terminology, credit allotment and course sequence, reciprocity with foreign schools, accepting positions in osteopathic hospitals, listing of degrees granted by schools of occupational therapy, and the possibility of an honorary society for occupational and physical therapists.

The Sub-Committee on Clinical Training has completed an outstanding piece of work on the Rater's Guide and Interpretational Key now in use in clinical training centers throughout the country. Other projects of this committee now under way are: 1) a student manual for clinical training which is the corollary of the director's manual; 2) a clinical training pool for use by both schools and training centers in placement of students; 3) the evaluation and accreditation of clinical training centers; and 4) the yearly reciprocal evaluation of schools and training centers based on the immediate reactions of students and directors.

The Education Committee has been working on revision of the American Medical Association *Essentials* for schools of occupational therapy. It has also drafted a statement of policy for the American Occupational Therapy Association concerning the relationship of occupational therapy and physical medicine. This statement was approved and accepted by the Board of Management; it had previously been unanimously approved by the House of Delegates.

It was voted to approve the revisions of the *Essentials* as recommended.

The report of the Education Committee was accepted with appreciation.

Report of the Registration Committee. Miss Otto transmitted the following recommendation from the Registration Committee to the Board of Management: "That credit allowed for work experience prior to professional education not exceed the equivalent of four months of clinical training; that such experience must have been under the supervision of a registered occupational therapist in a department of high standing; and that all clinical training areas listed under the *Essentials* of the American Medical Association must have been covered before a graduate becomes eligible for the Registration Examination."

The Board voted to accept this recommendation and the Registration Committee authorized the Educational Field Secretary to relay it to all school directors.

There were no other recommendations from the Registration Committee to the Board. The complete report of this Committee is published in the September-October, 1948 issue of the American Journal of Occupational Therapy.

Report of the Legislative Committee. Miss Messick reported that the Legislative Committee had been assisting various state groups in the re-classification of occupational therapy positions from the sub-professional to the professional series in Civil Service. It has been proposed that a survey of the problems of state associations in legislative and Civil Service matters be made thru state delegates so that the Committee may know how best to assist with these problems. Delegates will be sent questionnaires for this purpose.

The report was accepted with appreciation.

Report of the Clinical Research and Service Committee. Miss Welles reported from the Sub-Committee on General and Physical Function that approximately one-third of the total number of pages to be included in the *Manual of Adapted Equipment* have been completed by the professional architectural drawing artist and submitted to W. B. Saunders and J. B. Lippincott, publishers, for their consideration. The Lippincott Company is very much interested and will probably undertake publication. The manual will be an 8½" x 11" bound volume, will consist of photographs, scale drawings and legends for approximately 60 items of adapted equipment, and will retail at $3.00. Royalties at 22c per copy will be returned to the Association and earmarked to finance a revision at such time as the first printing of 1500 copies is sold out. The sale of 1000 copies of this original printing will guarantee a second printing. The first printing is being financed anonymously. The Board authorized Miss Welles to conclude all arrangements with the publisher.

The Sub-Committee on Psychiatry has completed a collection of sample prescriptions, progress notes and case studies which is now available from the National Office at 50c per copy. It has also been working for closer co-ordination with the American Psychiatric and Mental Hygiene Associations to promote occupational therapy section meetings at the annual conventions and state meetings of the groups.

The Committee as a whole has been studying the establishment of a clinical affiliation rotation plan designed to provide an interchange of experience among practicing therapists. Many practical considerations make the implementation of this plan difficult and, at the start, two pilot plans (in New York City and Los Angeles) will be put into effect on a trial basis. Unemployed and vacationing occupational therapists are being urged to participate.

Miss Welles' report was accepted with appreciation and the request of the Board of Management that she relay special thanks to the financial backer of the Manual.

Report of the Permanent Conference Committee. Mrs. Murphy reported official figures on the attendance at the 1948 Convention as follows: 592 paid members, 209 guests, total 801, making the largest convention attendance in history.

Of the four principal sites being considered for the 1949 Convention, Mackinac was too expensive, Interlaken too "informal" (necessary to supply own linen, etc.) and French Lick Springs expensive, hot in August and not conveniently accessible. The Book-Cadillac Hotel in Detroit was therefore voted by the Board and the dates set as August 20-27, 1949. Commercial exhibits will be included.

The Board of Management also voted for October as convention month in 1950 and recommended that effort be made to establish October as the permanent convention month.

It was voted that the 1950 convention would be held in Colorado and 1951 in Northern New England. The permanent Conference Chairman was authorized to complete hotel arrangements and dates.

At the suggestion of the Chairman, the Board of Management voted the establishment of the following policies regarding future conventions: 1) a standard registration fee of $5.00 for all members on presentation of membership card; 2) free admittance of doctors, nurses, social service workers and physical therapists on presentation of their respective cards; 3) registration fee of $6.00 to all others; 4) registration fee for student members $1.00, on presentation of card; 5) non-member students $6.00; 6) daily registration fee of $2.00, with different colored cards for each day; 7) for the Institute, fee of $2.00 per half-day; 8) honorarium for Institute speakers of $10.00 per hour.

Report accepted with appreciation.

Report of the Public Relations Committee. Miss West, acting since November, 1947, as temporary chairman of this committee, summarized the principal activities of the National Office as related to public relations. These included meetings with the American Medical Association, the American Congress of Physical Medicine, the American Physical Therapy Association, the U.S. Public Health Service, the National Foundation for Infantile Paralysis and the Medical Department of the U.S. Army. American Occupational Therapy Association sponsored exhibits and demonstrations were included in the 1948 annual meeting of the American Medical Association and at the First International Conference on Poliomyelitis. Two surveys were conducted for institutions wishing to organize occupational therapy departments. Talks were given to four state associations. Chapters on occupational therapy were written for two books and the manuscripts for two career books on occupational therapy read and approved. Information was also given to newspaper and magazine writers for articles on occupational therapy.

This report was accepted with appreciation. The report on American Journal of Occupational Therapy was deferred to a later item on the agenda.

Report of the Special Committee on Poliomyelitis. Miss Hurt reported that the National Foundation for Infantile Paralysis had approved the request made by the AOTA for a grant of $4,380.00. This amount is to be used for subsidy of the training of twelve registered occupational therapists for one month's intensive study in dissection anatomy, kinesiology, and the application of occupational therapy in the treatment of the poliomyelitis patient. The course will be given by the University of Southern California in the summer of 1949 and screening of applications for the scholarships done by the Polio Committee in consultation with representatives of the National Foundation for Infantile Paralysis.

The Committee has also requested admission of occupational therapists to the postgraduate courses offered at Georgia Warm Springs Foundation. Dr. Bennett, Physical Medicine Director of the Foundation, has indicated that occupational therapists would be accepted, though not yet on a scholarship basis. It is hoped that this subsidy will also be approved in the near future.

Miss West commented briefly on the demonstrations planned by the National Office, at the request of the Polio Committee, for the First International Conference on Poliomyelitis held in New York in July. Miss Charlotte Steitz, Director of Occupational Therapy at Warm Springs and Miss Doris Arink, Director of Occupational Therapy at Knickerbocker Hospital in New York handled the demonstrations of the role of occupational therapy in the convalescent phase.

Miss Hurt's report was accepted with appreciation.

Report of the Special Committee on Exhibits. Report accepted as given by the Chairman, Miss Ella Fay, at the general session.

Report of the Special Committee on Rules and Procedures.

Sister Jeanne-Marie presented a complete report of the activities to date and future recommendations of the Rules and Procedures Committee. The following nine points were included in the recommendations: 1) that the individual functions of all standing committees be written into the Constitution or/and printed in a Handbook of Rules and Procedures for Committee Chairmen; 2) that a history of service of each of the standing committees be written and filed in the National Office; 3) that a statement be published annually of the current work of all committees to avoid duplication, correlate group efforts and encourage inter-committee communication; 4) that a permanent file of copies of all committee reports be established in the National Office; 5) that committee membership be improved by avoiding overburdening of individuals by appointment of the same persons to several committees, and by stimulating interest of new members in committee service; 6) that conflicts of meeting times at convention be avoided; 7) that there be budget provision for committee expenses; 8) that more committee chairmen be presented to the membership at conventions and that brief reference be made to their work; and 9) that all members of committees be informed, at time of appointment, of the length of time they are expected to serve.

The Board of Management instructed the Committee to proceed with points one through four and that after the named material had been collected, further consideration would be given to the matter of its publication. The fifth recommendation was approved and the sixth referred to the Permanent Convention Committee. The seventh was thought to be a matter of lack of time rather than of money. Number eight was approved and nine referred to the President for action.

Thanks and appreciation were expressed to the Chairman for the excellent work of the Committee which has long been needed. The report was accepted.

Report of the Special Committee on Nominations. Miss Faeser reported results of the 548 ballots cast in 1948 elections to the Board: Fellow—Dr. Walter E. Barton; Board of Management Members—Miss Margaret Gleave, Miss Sue Hurt and Miss Carlotta Welles; Delegate Board Members—Miss Edna Faeser (Speaker), Miss Meryl Van Vlack and Miss Doris Wilkins.

Consideration of Revision of Public Relations Committee. Since the November, 1947, resignation of Mr. Holland Hudson as Treasurer and Chairman of the Public Relations Committee, no new Chairman of this Committee was appointed. It was the feeling of the President that the need for curtailing expenditures and the difficulty of carrying out a public relations program from anywhere but the National Office made a new appointment impractical. The Executive Director was therefore asked to promote such public relations as were feasible until further consideration might be given this matter.

The Board of Management discussed the question and decided that, since a large number of the activities of the National Office were along the lines of public relations, the existence of an Association standing committee for this purpose was unnecessary. It was voted to dissolve the Public Relations Committee and absorb its duties and responsibilities in the National Office.

Publication and Editorial Matters Concerning the American Journal of Occupational Therapy. With the resignation of Mr. Cleaves as publisher, submitted to the Board March 22, 1948, to be effective with the automatic expiration of the publishing contract on December 31, 1948, it became necessary to make new arrangements for future publication of the magazine. Since Miss Bone indicated an interest in taking over publication duties formerly handled by Mr. Cleaves, she was asked to submit an estimate of the additional expense account and salary required for this purpose. They are itemized below as presented to the Board of Management meeting. This proposed budget estimates complete editorial and publication expenses for the magazine for the calendar year 1949, and includes both the original estimate and the revised figures prepared after the Treasurer requested that expenses be further cut.

ITEMS		Original Estimate	Revised Estimate
Salaries		$5,000.00	$4,500.00
Editor-Publisher	$3,000.00		
Secretary	2,000.00		
Travel and Hospitality		600.00	50.00
Rent (office and storage)		504.00	504.00
Equipment		415.00	415.00
Production		8,730.00	7,980.00
Printing	7,260.00		
Cuts	900.00		
Storage	150.00		
Mailing service	264.00		
2nd Class Mail Permit	156.00		
Maintenance		1,200.00	1,200.00
Supplies	250.00		
Phone	300.00		
Sales Expenses	400.00		
Other	250.00		
TOTALS		$16,449.00	$14,649.00

It was pointed out that even at the revised estimate the magazine's editorial and publication expenses would amount to 80c per issue, whereas 2500 of the 2800 copies of each issue subscribed to bring in only 50c per issue. Expenses would therefore be considerably greater than income and the discrepancy could not be entirely absorbed by additional revenue obtained from advertising.

The Treasurer also pointed out the rising cost of our publication over the period of the past five years and the estimate

for the coming year. This is shown in the following set of figures which also shows income from membership and total income.

Fiscal Year	Total AOTA Income (Gen'l Fund Only)	Income from Membership	Publication Expenses
1943-44	$17,292.08	$ 8,873.50	$ 3,580.06
1944-45	21,115.75	10,240.76	4,258.04
1945-46	37,299.20	12,514.25	5,311.75
1946-47*	35,463.74	14,809.50	11,452.86
1947-48	34,846.78	19,440.00	12,676.51
1948-49 (Est'd)	37,800.00	21,000.00	14,649.00

*First year of the *American Journal of Occupational Therapy.*

Three deductions were brought out from the above: first, that the *Journal* more than doubled publication expenses in its first year and if the estimate for 1949 were accepted it would be nearly tripled; secondly, that although less than half of the income from membership dues is allocated to the magazine ($3.00 out of $8.00) considerably more than half would be spent under the proposed plan; and third, that publication expenses, formerly using less than one-fifth of the total AOTA income, have risen to more than one-third.

It was unanimously agreed by the Board of Management that the *Journal* itself is our best public relations instrument and extremely important to the profession but there was a question as to whether the Association could afford to allocate that proportion of its total income to the publication. Although it was inevitable that a new publication would be far more costly in its beginning establishment, it was felt that continually increasing expenses must soon be curtailed.

Ways and means of increasing revenue through circulation and advertising were discussed. Miss Bone also reported that Mr. Hudson had suggested approaching the Carnegie Foundation for a grant to help support the *American Journal of Occupational Therapy* until expenses could be stabilized. Dr. Dunton stated that he had approached them a number of years ago with regard to subsidy of a book on occupational therapy and that they had been generally unsympathetic and would have considered such only on a loan basis.

The Board of Management voted to withhold final decision in the matter until further study of the cost of publishing could be made. It therefore authorized the Executive Committee to conduct an investigation of the possibility of publishing the *Journal* on a basis adjusting expenses to income. The study was to be completed by November 1 and the Executive Committee was further empowered to proceed, on the basis of findings, to complete arrangements for both editorial and publication matters. On completion of the investigation, it was voted that the Carnegie Foundation might, if it seemed warranted, be approached for a grant in support of the *Journal* for future years.

One other question from the Editor was for reconsideration of a previous Board of Management vote disapproving the policy of carrying advertising for jobs in the magazine. The Board reversed its original decision and voted to authorize the *Journal* to carry ads from institutions for therapists and from registered therapists for jobs. A separate advertising rate, in keeping with other magazines' policies in similar matters, was to be established.

It was also voted by the Board of Management that the full $5.00 of non-member subscriptions would be credited to *Journal* income, effective January 1, 1949. This action reversed previous policy of maintaining $2.00 of each 5-dollar subscription in the General Fund and not allocating it to the *Journal* expense.

New Business.

1. Selection of Candidates for Women's National Institute Awards. At the request of the Women's National Institute, the Board of Management chose four "Women of Achievement" and one "Ideal Career Girl" to be the recipients of awards at the 1948 Women's International Exposition. Many names were submitted by members of both the House of Delegates and the Board of Management and the following were voted:

For "Women of Achievement"
Miss Sue P. Hurt
Mrs. Winifred C. Kahmann
Miss Marjorie Taylor
Miss Helen S. Willard

For "Ideal Career Girl"
Mildred V. Bond, 1st Lt., WMSC (OT)

2. International Reciprocity. A request from Australia regarding this question was referred to the Registration Committee for study and recommendation back to the Board.

3. New AOTA Fellows. At the March, 1948, Board meeting, four new Fellows were voted by the Board to the Association. Questions about responsibility for payment of magazine subscription fees for these Fellows arose. The Board suggested that the Association of the state from which the Fellow came pay for his magazine, but the state associations felt this was a national matter and that the expense should therefore be borne by the AOTA. The Board voted to refer the matter for further study by the Constitution Committee, to be appointed by the President.

There being no other business, the meeting was adjourned.

Respectfully submitted,

WILMA L. WEST, OTR.
Executive Director

CLASSIFIED ADVERTISING

Classified advertising accepted for POSITIONS WANTED and POSITIONS AVAILABLE only. Minimum rate $2.00 for 3 lines; each additional word ten cents. (Average 51 spaces per line). Copy deadline first of each month previous to publication.

POSITIONS AVAILABLE

Fairfield State Hospital, Newton, Connecticut. Positions available: O.T. minimum gross salary $2418: Senior O.T. minimum gross salary $3018. Maintenance deductible $316 per annum.

Occupational Therapists for large psychiatric hospital located in New England. Progressive, all-inclusive program for patients. Student affiliations with excellent educational program. Modern home, good food, maintenance optional. Liberal retirement plan and illness policy. Paid vacation and holidays. Write to Director of Occupational Therapy, Norwich State Hospital, Norwich, Conn.

Wanted—O.T. for rapidly growing Curative Workshop. Responsible for Department and all prescribed treatments. Salary $225. No Saturday work. Write Miss Nell McCulloch, O.T.R., Director, The Curative Workshop, 840 S. Third St., Louisville, Ky.

SCHOOLS OFFERING COURSES IN OCCUPATIONAL THERAPY

1948-49 School Year

Name of School	Name and Address of Director	Yearly Tuition	Type of Course	Entrance Requirements	Classes Start	Length of Course	Students M	Students F	Enrollment
Boston School of Occupational Therapy Affiliated with Tufts College—School of Education	Mrs. John A. Greene, President Boston School of Occupational Therapy, 7 Harcourt Street, Boston 16, Massachusetts	$500 advanced course $450 for degree course	a. Advanced Course (Diploma) b. Degree (B.S. from Tufts plus B.S.O.T. diploma)	*College degree or accredited professional training Secondary school diploma or qualified transfer student	Sept. Sept.	Approximately 20 months Approximately 44 months	No No	Yes Yes	108
†Colorado Agricultural and Mechanical College Division of Home Economics	Asst. Prof. Helen Tobiska, OTR Director of Occupational Therapy Division of Home Economics Colorado Agricultural and Mechanical College Fort Collins, Colorado	$180 $230 out-of-state residents	Degree (B.S.)	As for the College	Sept.	4 ac. yrs. plus 10 mo. clin. tr.	Yes	Yes	43
Columbia University College of Physicians and Surgeons	Miss Marjorie Fish, OTR, Director Miss Marie Louise Franciscus, OTR, Acting Director of Training Courses in Occupational Therapy Columbia University, College of Physicians and Surgeons, 630 West 168th St., New York 32, New York	$600	a. Degree (B.S. in O.T.) b. Certificate from Faculty of Medicine	*2 yrs. college *A.B. or B.S.	Sept. Sept.	27 months 17 months	Yes Yes	Yes Yes	71
†Iowa, State University of College of Liberal Arts and College of Medicine	Miss Marguerite McDonald, OTR Occupational Therapy Supervisor Division of Physical Medicine College of Medicine State University of Iowa Iowa City, Iowa	$130 $300 out-of-state residents	a. Degree (B.S. from College of Liberal Arts) b. Certificate from College of Medicine	*Entrance requirements of the university	Sept. Feb. Sept. Feb.	36 months The above plus 9 mo. clinical training	Yes Yes	Yes Yes	44
Illinois, University of College of Medicine	Assoc. Prof. Beatrice D. Wade, OTR, Director of O.T. Curriculum Department of Physical Medicine Section of Occupational Therapy University of Illinois 1853 West Polk Street Chicago 12, Illinois	$55 $101 for out-of-state residents	Degree (B.S. in O.T.) from College of Medicine	Entrance requirements for college Upper 50% of class Special physical examination	Oct. Feb.	6 college semesters on Urbana campus 16 months on Chicago campus and affiliating hospitals	Yes	Yes	74
Kalamazoo School of Occupational Therapy of Western Michigan College of Education	Assoc. Prof. Marion R. Spear, OTR, Director of Occupational Therapy Kalamazoo School of Occupational Therapy of Western Michigan College of Education Kalamazoo 45, Michigan	$127 $202 for out-of-state residents	a. Degree (B.S. with major in O.T. & diploma) b. Diploma only	30 semester hrs. of college credits As above Degree	Sept. Feb.	Approximately 4 academic years As above	Yes Yes Yes	Yes Yes Yes	158
Kansas, University of School of Occupational Therapy	Asst. Prof. Nancie B. Greenman, OTR, Director of Occupational Therapy University of Kansas Lawrence, Kansas	$80 $180 out-of-state residents	a. Degree (B.S. in O.T.)	Accredited Kansas High School graduate	Sept. Feb.	45 months	No	Yes	92

Name of School	Name and Address of Director	Yearly Tuition	Type of Course	Entrance Requirements	Classes Start	Length of Course	Students M	Students F	Enrollment
Michigan State Normal College	Asst. Prof. Gladys Tmey, OTR Supervising Director of Occupational Therapy Michigan State Normal College Ypsilanti, Michigan	$118 $193 out-of-state	Degree (B.S. with major in O.T.)	*Entrance requirements of the college	Feb. June Sept.	45 months	Yes	Yes	80
Mills College	Mrs. Elsa H. Hill, M.A., OTR Director of Occupational Therapy Mills College Oakland 13, California		a. Degree (B.A. with major in O.T. plus certificate)	Entrance requirements of the college	Sept. Feb.	37 months	No	Yes	
			b. Certificate	Degree from accredited college	Sept. Feb.	20-23 months	No	Yes	
Milwaukee-Downer College	Prof. Henrietta McNary, OTR Director, Department of Occupational Therapy Milwaukee-Downer College 2512 East Hartford Ave. Milwaukee 11, Wisconsin	$350	a. Degree (B.S. with major in O.T.)	*Graduate of accredited high school	Sept.	46 months	No	Yes	117
			b. Diploma	*As above plus 1 year college or professional training	Sept.	28 months	No	Yes	
Minnesota University of School of Medicine	Miss Borghild Hansen, OTR Director of Occupational Therapy University of Minnesota Minneapolis, Minnesota	$126 $270 out-of-state	Degree (B.S. in O.T.)	*High school graduate plus 2 yrs. in Arts College	Sept.	39 months	Yes	Yes	86
Mount Mary College	Sister Mary Arthur, OTR Director of Occupational Therapy Mount Mary College Milwaukee 13, Wisconsin	$200	a. Degree (B.S.) and Certificate	Accredited high school graduate	Sept.	45 months	No	Yes	41
New Hampshire, University of College of Liberal Arts	Asst. Prof. Doris F. Wilkins, OTR Supervisor of Occupational Therapy Curriculum University of New Hampshire Durham, New Hampshire	$160 $360 out-of-state residents	a. Degree (B.S. with major in O.T. plus Certificate	*High school graduate	Sept.	32 months Above plus 9 months	Yes Yes	Yes Yes	71
New York University School of Education	Miss Frieda J. Behlen, OTR Director of Occupational Therapy Curriculum New York University Washington Square New York 3, New York		a. Degree (B.S.) and Certificate	*High school graduate	Sept. Feb. June	42 months	Yes	Yes	
			b. Certificate	One year college	As above	32 months	Yes	Yes	
			c. Graduate (M.A.) OTR with college degree.						

Name of School	Name and Address of Director	Yearly Tuition	Type of Course	Entrance Requirements	Classes Start	Length of Course	Students M	Students F	Enrollment
Ohio State University College of Education	Prof. Martha E. Jackson, OTR Chairman, O.T. Department Ohio State University Columbus 10, Ohio	$30 per quarter $105 per quarter out-of-state residents	Degree (B.S. in O.T.)	High school graduate	Sept.	39 months	Yes	Yes	55
Philadelphia School of Occupational Therapy Affiliated with University of Pennsylvania—School of Education	Miss Helen S. Willard, OTR Director, Philadelphia School of Occupational Therapy 419 South 19th St. Philadelphia 46, Pa.	$500	a. Degree (B.S. from University plus diploma of P.S.O.T.)	*High school graduate	Sept. Feb.	42 months	No	Yes	89
			b. Diploma	*1 year college	Sept.	26 months	No	Yes	
			c. Advanced Standing	*College degree or professional training	Sept.	18 months	No	Yes	
Puget Sound, College of	Miss Edna-Ellen Bell, OTR Director of Occupational Therapy and Rehabilitation College of Puget Sound North 15th and Warner St. Tacoma 6, Washington	$300	a. Degree (B.A. or B.S. with major in O.T.)	High school graduate	Sept. Jan.	45 months	Yes	Yes	43
			b. Certificate	Degree from other college or university	Sept. Jan.	27 months	Yes	Yes	
Saint Catherine, College of	Sister Jeanne Marie, OTR Director of Occupational Therapy The College of St. Catherine St. Paul 1, Minnesota	$210	Degree (B.S.)	*Special	Sept. Jan. March	36-45 months	No	Yes	40
San Jose State College	Asst. Prof. Mary Booth, OTR San Jose College San Jose 14, California	$21	a. Degree (B.A.)	High school graduate	Oct. Jan. April	45 months	Yes	Yes	117
			b. Certificate	College degree	As above	18 months Minimum	Yes	Yes	
Southern California, University of College of Letter, Arts and Sciences	Prof. Margaret S. Rood, OTR Head, Department of Occupational Therapy University of Southern California Box 274, Los Angeles 7, California	$516	a. Degree (B.S.) plus certificate	*High school graduate (upper ½ of class)	Sept. Feb. July	45 months	Yes	Yes	81
			b. Advanced Standing (Certificate)	College degree	As above	18 months	Yes	Yes	
			c. Graduate (M.A.)	OTR or eligible for OTR with college degree	Sept.	9 months	Yes	Yes	
Texas State College for Women Department of Art	Assoc. Prof. Fanny Vanderkooi, OTR, Supervisor of O.T. Course Texas State College for Women Denton, Texas		a. Degree (B.S. or B.A. with major in O.T.)	High school graduate	Sept. Feb.	45 months	No No	Yes Yes	46

Name of School	Name and Address of Director	Yearly Tuition	Type of Course	Entrance Requirements	Classes Start	Length of Course	Students M	Students F	Enrollment
Toronto, University of Department of University Extension	W. J. Dunlop, B.A., B.Paed., LL.D., Dir. University Extension Course in Occupational Therapy University of Toronto Toronto, Canada		Diploma	Senior Matriculation	Sept.	32 months	No	Yes	
Washington University School of Medicine	Professor Sue P. Hurt, OTR Dir., Dept. Occupational Therapy Washington University School of Medicine 4567 Scott Ave., St. Louis 10, Mo.	$400	Degree (B.S. in O.T.)	Two years of college totalling 60 sem. hrs., 36 of which are in required subjects.	Sept.	27 months	Yes	Yes	35
Wayne University College of Liberal Arts and College of Education	Asst. Prof. Barbara Jewett, OTR Director of Occupational Therapy Wayne University Detroit 1, Michigan	$150	a. Degree (B.S. in O.T.)	High school graduate	Sept. Feb. June	46 months	Yes	Yes	45
			b. Post Degree Certificate	*College degree	As above	19 months	Yes	Yes	
William and Mary, College of Richmond Professional Institute	Miss Elizabeth Messick, O.T.R., Dir. O.T. Training Course Richmond Professional Institute of The College of William and Mary 901 W. Franklin St., Richmond 20, Va.	$200	a. Degree (B.S. in Psychology)	High school graduate	Sept.	45 months	Yes	Yes	44
		$300 out-of-state residents	b. Certificate	1 year college	Sept.	27 months	Yes	Yes	
			c. Ad. Standing	College degree	Sept.	19 months	Yes	Yes	
Wisconsin, University of School of Medicine	Asst. Prof. Caroline G. Thompson, OTR Technical Director of Course in O.T. University of Wisconsin 1300 University Ave., Madison 6, Wis.	$120 $320 out-of-state residents	Degree (B.S. in O.T.) from School of Education plus certificate from School of Medicine	As for university	Sept. Feb.	33 months	Yes	Yes	94

*Schools having additional requirements.

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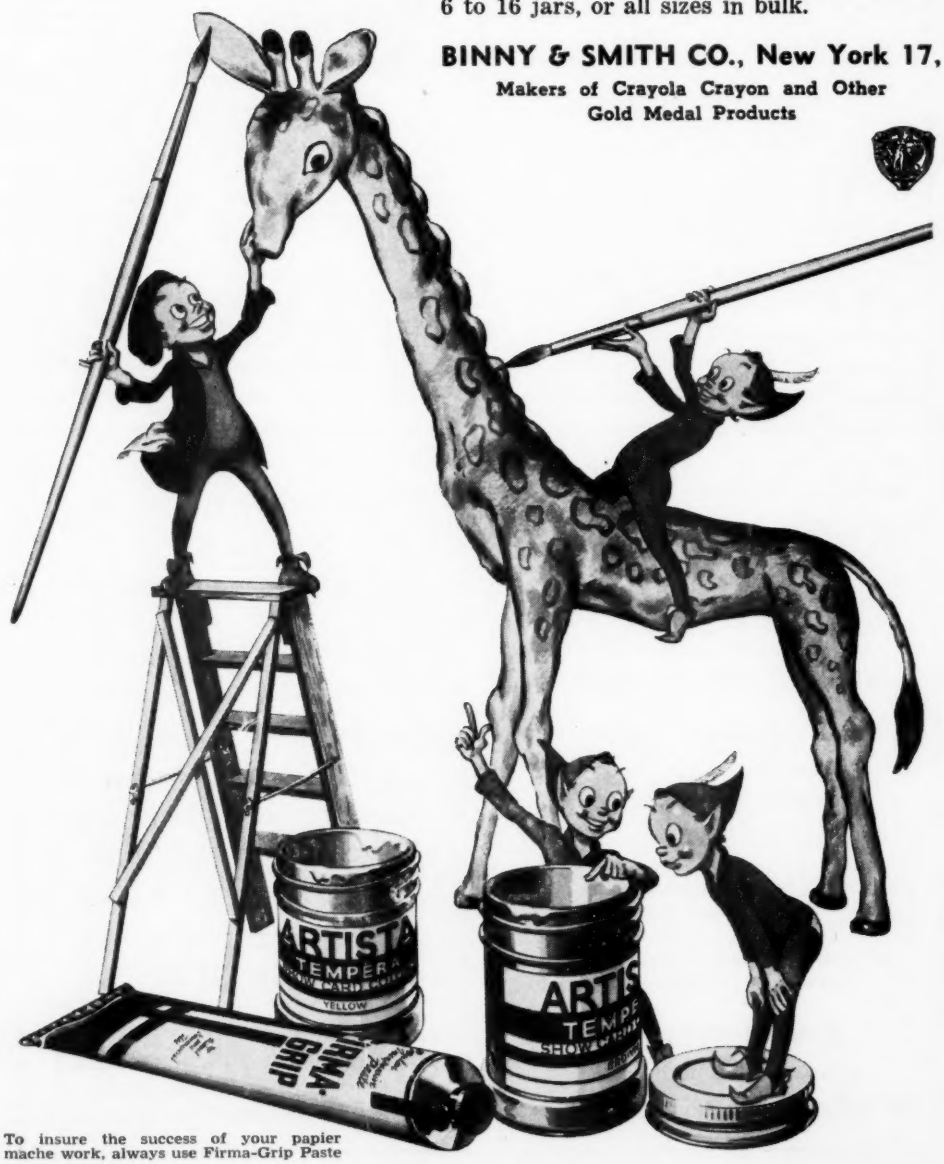

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